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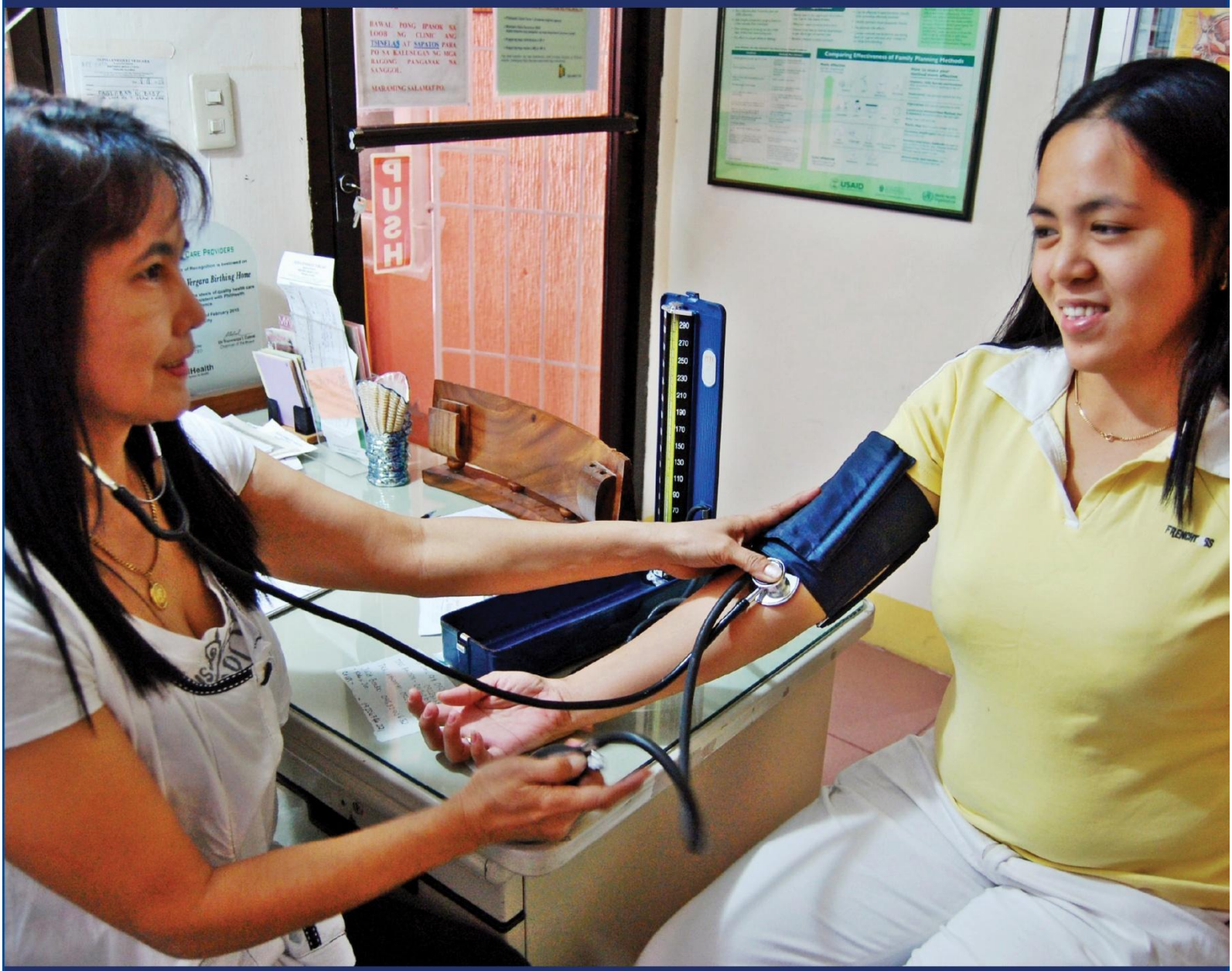
Quality Assurance Package (QAP) for Midwives

A Toolkit for Practicing Professional Midwives

Facilitator's Guide



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Facilitator's Guide

July 2014

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Table of Contents

Acronyms

AO	Administrative Order
AOG	Age of Gestation
AMSTL	Active Management of the Third Stage of Labor
CBC	Complete Blood Count
CCC	Clinical Case Conference
DOH	Department of Health
DOH-RO	Department of Health-Regional Office
HHRDB	Health Human Resources Development Bureau
NCDPC	National Center for Disease Prevention and Control
EDD	Expected Date of Delivery
EINC	Essential Intrapartum and Newborn Care
FP-MCH	Family Planning and Maternal and Child Health
QAP	Quality Assurance Package
TT	Tetanus Toxoid
USAID	United States Agency for International Development

About this document

This document was developed to guide facilitators who conduct the Workshop on Quality Assurance Package (QAP) for Midwives. The goal is to ensure that there is a unified understanding of the standards, tools and processes of family planning and maternal and child health (FP-MCH) in the QAP quality standards of care and that these are correctly practiced and applied.

Included in this facilitator's guide are the following details of the workshop:

1. Section objectives
2. Required materials
3. Methodology
4. Process / Guide on the facilitation of each session
5. PowerPoint slides for each section; with speaker's notes

The two-day QAP workshop has four main parts which are based on the sections of the QAP Toolkit for Practicing Professional Midwives. These sections are:

Section 1: Clinical Care Manual for Midwives – provides the standard of care for practicing midwives' professional conduct.

Section 2: Clinic Operation Standards Manual – guides midwives on how to operate and manage a birthing home. This manual provides guidelines on the standard operating procedures for various clinic tasks, and gives guidance on what clinic forms are necessary for recording client data and how to accurately fill out those forms.

Section 3: Monitoring Tool for Practicing Midwives – guides midwives on how to perform a self-assessment. Midwives review their own practices and determine the level of quality that FP-MCH services are being provided to clients; midwives identify the areas that need to be improved and draft action plans to address deficiencies. Midwives are also introduced to the Monitoring Tool, which will be used by Midwife Supervisors to validate the self-assessment.

Section 4: Guide to Organizing and Managing the Conduct of a Clinical Case Conference (CCC) for Midwives – provides step-by-step guidelines for midwives on how to organize and manage the CCC, serving as a continuing quality improvement activity.

Introduction

Rationale

Achieving the Millennium Development Goals 4 and 5 targets remains a big challenge for the country. The latest maternal mortality ratio of 162 per 100,000 live births and infant mortality rate of 25 per 1,000 live births are far from the target maternal mortality ratio of 52 and infant mortality ratio of 19 by year 2015. To facilitate the achievement of the Millennium Development Goals, the Department of Health issued Administrative Order No. 2008-0029 on September 9, 2008, entitled "Implementing Health Reforms for Rapid Reduction of Maternal and Neonatal Mortality." Among others, it seeks to increase the number of deliveries attended by skilled birth attendants and decrease the number of deliveries occurring at home by promoting deliveries at adequately-equipped birthing facilities with trained birth attendants.

At the forefront of the country's health care delivery system, and key to achieving national health goals and programs, are the estimated 20,000 professional midwives mostly employed by the government. Midwives are the most numerous community-based, first-contact, skilled birth attendants. They can play a key role in reducing maternal and neonatal deaths, since the two most significant factors contributing to maternal deaths in the country are deliveries by unskilled birth attendants and deliveries occurring at home.

A "Quality Assurance Package for Midwives: A Toolkit for Practicing Professional Midwives" was developed to ensure that midwives in both public and private practice adhere to quality standards in their provision of Maternal, Neonatal and Child Health and Nutrition services, either in government birthing facilities or in private clinics. It aims to provide continuing quality improvement by setting standards of quality care, and providing an opportunity for midwives to conduct their own technical self-assessment, followed by technical monitoring and assistance by their supervisors.

This set of standards and tools are designed for use of both midwives themselves and their supervisors who may come from their own midwives associations, from the DOH-Regional Offices (DOH-ROs), or from local government units such as the Provincial Health Offices and the City Health Offices.

Background

The DOH-Health Human Resources Development Bureau (HHRDB), in its efforts to ensure that service providers at the grassroots level continuously provide quality services in the community, began developing a clinical care protocol that was intended for use by public sector practicing midwives. At the same time, the USAID Private Sector Mobilization for Family Health project was also developing and using a quality measurement tool designed to objectively monitor the quality of services provided by private midwives under the project.

In July 2008, DOH-HHRDB and USAID started working together to develop standard materials that can be used by both public and private midwives. After months and a series of consultative meetings, working drafts, testing the materials, the package was finally developed in June 2009, updated in July 2010 and in April 2011, and finally completed in 2012. Roll-out of the QAP to the midwife supervisors and midwives were conducted by the Private Sector Mobilization for Family Health-Phase 2 (PRISM2) project starting February 2013.

Pre-Test and Post-Test

PRE-TEST

Duration: 10 minutes

Objectives: The pre-test aims to determine the level of knowledge of the participants prior to the workshop.

Materials:
- Printed copies of the pre-test (with 10 multiple choice questions)
- Writing pen / pencil

Methodology: Written examination

Process:
1. Conduct the pre-test in the morning before the start of the workshop on Day 1.
2. Distribute the pre-test questionnaire.
3. Ask participants to label their test papers using either their real name or an alias/pseudonym. Remind the participants to use the same alias/pseudonym on both the pre- and post-test.
4. Instruct participants to write the letter of the best answer on the space provided before each question.
5. Check the participants' answers. Count and record the number of correct answers of each participant.

POST-TEST

Duration: 10 minutes

Objectives: The post-test aims to determine the level of knowledge gained by the participants from the workshop.

Materials:
- Printed copies of the post-test (with 10 multiple choice questions)
- Writing pen / pencil

Methodology: Written examination

Process:
1. Conduct the post-test before the closing ceremonies on Day 2 of the workshop.
2. Distribute the post-test questionnaire.
3. Ask participants to label their test papers using either their real name or an alias/pseudonym. Remind the participants to use the same alias/pseudonym on both the pre- and post-test.
4. Instruct participants to write the letter of the best answer on the space provided before each question.

5. Check the participants' answers. Count and record the number of correct answers of each participant. At the end of the two-day workshop, compare the results of the pre-test with those of the post-test.
6. The facilitators may decide to discuss the results of the pre/post test with the entire group of participants

Pre/Post-Test Questions: Refer to Annex A for the Pre/Post-Test Questions and to Annex B for the Answer Key.

Levelling of Expectations

Duration: 30 minutes

Objective: At the end of this session, each participant should:

- Have introduced her/himself to the group, sharing her name and birthing home affiliation
- Have identified her/his strongest point and her areas for improvement
- Have identified her/his expectations from the workshop

Training Materials:

- Tarpaulins, with pre-printed items - minimum size of 20 inches x 30 inches (Annex C)
- Metacards (blue, pink, and green), each cut into small squares (3 inches x 3 inches)
- Double-sided tape

Methodology:

- Brief lecture
- Interactive exercise

Process:

1. Ask each participant to briefly introduce her/himself he; including name and birthing home affiliation
    a. Encourage participants to share more about themselves; for example, ask if you were a celebrity, who would you be? Why? Or, which celebrity do you look like?

2. Ask trainers, other facilitators, and support staff to introduce themselves.

3. Distribute the color-coded metacards to the participants.

4. Ask the participants to identify their strongest point and areas that need improving by placing color-coded metacards on the pre-printed tarpaulins
    a. Blue metacard – strongest point (each participant can put only one blue metacard on the tarpaulin)
    b. Pink metacard – areas that need improvement (each participant can place as many pink metacards as they wish on the tarpaulin)

5. Ask the participants to identify their expectations from the workshop by placing a GREEN metacard on the corresponding pre-printed tarpaulin. Each participant can place as many green metacards as they wish on the tarpaulin.

6. Summarize or give an overview of the participants' responses.

PowerPoint Slides

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LEVELLING OF EXPECTATIONS

QAP TRAINING

1. Rate the following items by placing a metacard next to your strongest point *(blue)* and another metacard next to the area that you need improvement *(pink)* as a midwife.

❑ Planning	❑ Referrals
❑ Clinical skills	❑ Problem Solving
❑ Filling out forms	❑ Decision Making
❑ Data Analysis & Assessment	❑ Others (specify)

2. What processes / procedures / methods do you expect from this QAP training that may boost your role(s) and functions(s) as a midwife? *(green)*

- ❑ Self-Assessment checklist/tool
- ❑ Planning Sessions
- ❑ Capacity building / Retooling
- ❑ Clinical Case Conference
- ❑ Fund sourcing
- ❑ Service Provision Profiling / Baselining
- ❑ Records keeping and Feedbacking
- ❑ Others (specify)

Rationale for the QAP/Overview of the Program

Objectives of the QAP Workshop
The QAP workshop aims to enhance the knowledge and skills of practicing midwives, with the use of the QAP manual to ensure their compliance with quality standards of care and practice. The goal is that participants will: (1) have a basic understanding of the different sections of the QAP Manual; (2) be familiar with the Midwives Self-Assessment Tool and be able to use the tool; (3) be more skilled in accomplishing the Standard Clinic forms; and (4) know how to do action planning and be able to actualize the planned actions.

QAP Workshop Participants
Intended workshop participants are private and public practice midwives. It is recommended that each workshop has a maximum of 35 participants.

Methodology
The methodology to be used is a combination of lectures, workshops, group discussions, and case studies.

Program Design
The workshop is a two-day program Annex D. Each section of the QAP Manual is discussed.

Preparations Needed:
- Training venue
- LCD projector
- Projector screen
- One set of the QAP Manual for Midwives (consisting of 5 booklets)

The complete checklist for all materials needed is given in Annex E.

Duration: 15 minutes

Objectives: At the end of the session, the participants will:
- Know the background of and rationale for the development of the QAP Manual
- Know the content of the QAP toolkit for midwives
- Know the general and specific objectives of the QAP orientation workshop
- Know the methodology to be used
- Have a general overview of the program's two-day activities

Materials Needed: None

Methodology: Lecture

Process: Give a lecture on the background of and rationale for the development of the QAP, and provide an overview of the program.

PowerPoint Slides

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Background and Rationale

QAP Training

Discussion

Background/Rationale

2007 – DOH-HHRDB and PRISM1: recognized need for quality standards of care for midwives (DOH: midwives to the barrios/PRISM1 QMT for PPMs)

2010 – DOH-NCDPC and PRISM2: worked on revisions to align with BEmONC for midwives, ENC, AMTSL and other updates

2012 – DOH Secretary's Message/Foreword

Value: standardizes professional midwifery practice

Briefly discuss the chronology of events leading to the formulation of the QAP.

Quality Assurance Package for Midwives

(A Toolkit for Practicing Professional Midwives)

5 Booklets : 1 Introduction to the Manuals and 4 main sections

- **Clinical Care for Midwives**
  - Management
  - Special Procedures
- **Clinical Operation Standards**
  - Standard Operating Procedures
  - Standard Clinic Forms
- **Monitoring Tool for Practicing Midwives**
  - Midwives Portion
  - Supervisors Portion
- **Guide to Organizing and Managing of Clinical Case Conference for Midwives**

Briefly discuss the four manuals of the toolkit, as follows:

Section 1 - Clinical Care Manual for Midwives: This manual provides the standards of care in the professional conduct of practicing midwives.

Section 2 - Clinic Operation Standards Manual: This manual gives guidance to midwives on how to operate and manage a birthing home. It consists of two parts: Standard Operating Procedures and Standard Clinic Forms.

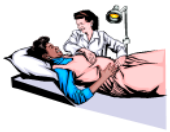
Section 3 - Monitoring Tool for Practicing Midwives: This allows midwives to review their own practices, make improvements, and seek outside assistance for resolving issues (midwife self-assessment portion), and guides supervisors on how to validate the midwife's self-assessment and progress in improving the quality of FP-MCH services (supervisor's monitoring tool).

The toolkit allows both midwife and supervisor the opportunity to address deficiencies and mobilize resources toward improving the quality of services in the birthing home.

Section 4 - Guide to Organizing and Managing the Conduct of Clinical Case Conference for Midwives: A user-friendly manual that provides step-by-step guidelines in organizing and managing the Clinical Case Conference (CCC) for Midwives as a continuing quality improvement activity.

General Objective

- To enhance knowledge and skills of practicing midwives to ensure compliance with quality standards of care and practice.
- To orient the PPMs on how to perform a self-assessment.



Read and clarify the objectives with the participants.

Specific Objectives

By the end of the orientation workshop, participants will :

1. Have an overview of the contents of the different sections of the QAP Manual
2. Be familiar with the MW Self-assessment Tool of the QAP and be able to use it
3. Be able to choose the correct forms for every client and be able to correctly fill in all the necessary entries in the forms.

Methodology

- Lecture/workshop-Discussion
- Self-Assessment Practice
- Case Studies
- Processing, Synthesis and Next Steps

Describe the different methodologies of the two-day workshop

Programme

DATE/TIME	TOPIC
Day 1	
8:00 AM	Registration of Participants
9:00 AM	Invocation
	National Anthem
9:10 AM	Welcome Remarks
9:20 AM	Pre-test
9:30 AM	Levelling of Expectations
9:45 AM	Overview of the Program / Objectives
	Rationale for the QAP
10:00 AM	Workshop - *Clinical Care for Midwives*
12:30 NN	LUNCH
1:30 PM	Worshop- *Clinic Operation Standards*
	What forms to use / how to accomplish each form
	Case Study - How to use the Partograph
4:30 PM	Synthesis of Day 1

Enumerate the topics for each day. Read from slide.

Programme

DATE/TIME	TOPIC
Day 2	
8:00 AM	Registration of Participants
8:15 AM	Lecture – MW self-assessment tool
11:00 AM	Processing of the self-assessment
12:00 NN	LUNCH
1:00 PM	Guide to Organizing and Managing Conduct of Clinical Case Conference for Midwives: didactics & practical application
2:00 PM	Action Plans / Next Steps
4:00 PM	Post-test
4:15 PM	Synthesis of Day 2
4:30 PM	Closing

Ask the participants if they have any questions on the program before proceeding to Section I.

SECTION 1
Clinical Care Manual for Midwives

Section 1: Clinical Care Manual for Midwives

Duration: 2.5 hours

Objectives: At the end of the session, the participants will understand the standards of care in the professional conduct of practicing midwives:

- Guidelines on the management of the different phases of pregnancy and delivery – prenatal, intrapartum, postpartum and newborn care
- Information and review some basic and special procedures that previously trained midwives are expected to perform. (This does not allow midwives to perform the procedures without the corresponding proper training).

Materials Needed:

- QAP Manual for Midwives – Section 1
- Workshop sheets – contains the case studies / participant exercises
- Writing materials –pen/pencil and extra paper

Methodology:

- Lecture/Discussion
- Workshops
- Case Studies

Process:

1. Give the objectives and mention the how the session will be conducted.

2. Present case studies and ask questions related to each case. Ask participants to raise their hands to indicate their answers. (ex., how many of you say the correct answer is A? B? C? D?)

3. For some of the questions, ask the participants to write their answers on the workshop sheets provided, and request that they give their answers during the discussion. To ensure everybody actively participates, pass the microphone around the room during the course of the discussion.

4. Explain the answers to the questions using the QAP Manual as a basis. Encourage participants to share their opinions, views, and experiences during the discussions.

PowerPoint Slides

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- Workshop on
- **QUALITY ASSURANCE PACKAGE**
- **FOR MIDWIVES**
- (Toolkit for Practicing Professional Midwives)

SECTION 1

Clinical Care Manual for Midwives

Section 1: Clinical Care Manual for Midwives

Part 1 : Management
- Guidelines in the management of the different phases of pregnancy, labor and delivery (prenatal, intrapartum, postpartum and newborn care)

Part 2 : Special Procedures
- A review of the correct steps in performing some basic and special procedures
- Special procedures that ONLY previously trained midwives are expected to perform

Objectives

By the end of the orientation workshop, participants will be able to:
- Guide their respective midwives on the proper management of labor and delivery, with this QAP as reference
- Give a training to their respective midwives on the practical application of the manual

Case 1

A 35 year-old came in for her prenatal check-up. Upon interviewing her it was discovered that her menses was 8 days late. The patient says that her LMP was one month and 2 days ago and included spotting; the PMP was 2 months and 6 days ago with minimal to moderate flow. She complains of nausea and vomiting and enlarged, tender breasts.

Read the case and proceed to the next slide for the question.

What would be included in your assessment / evaluation?

A. Pregnancy test, AOG determination, Bimanual Examination, refer to higher level of service
B. Pregnancy test, AOG determination, Bimanual examination
C. Bimanual Examination, request for ultrasound, manage the nausea and vomiting
D. Refer to higher level of service
E. None of the above.

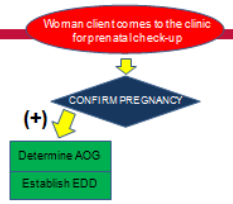
Ask the participants for their best answer to the question on the slide. Ask them to explain their answers and then discuss the answers with them.

The answer is: B. Pregnancy test, AOG determination, Bimanual examination.

The other options are not correct because: For A & D - There is no need to refer to a higher level of service. Nausea, vomiting, and enlarged, tender breasts are usual signs and symptoms of pregnancy. Referral will only be necessary if the symptoms become severe.

For C - Midwives are **not allowed to manage** nausea and vomiting. They **can only give advice** so clients can cope with the symptoms.

Prenatal Consultation



The Clinical Care Manual for Midwives gives guidance on how a midwife should manage clients. In the case presented in the previous slide, although the client says that her menses are delayed, the midwife should still confirm that she is pregnant.

Should her pregnancy be confirmed, the next step would be to determine the Age of Gestation (AOG) and the Expected Date of Delivery (EDD).

To establish the EDD, Naegele's Rule can be used:

EDD = first day of the last menstrual period + 9 months + 7 days OR

EDD = first day of the last menstrual period – 3 months + 7 days

Clinical Care Manual for Midwives

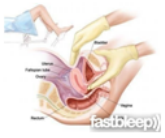
1. **Detect and Date the Pregnancy**
   A pregnancy test may be performed to confirm the pregnancy. If the result is negative but pregnancy is still suspected, repeat the test. The previous test might have been performed too early.

The easiest and quickest method of confirming a pregnancy is through a urine Pregnancy Test. The Pregnancy Test determines the presence of human chorionic gonadotropin (hCG), the hormone produced during pregnancy.

Most of the available pregnancy tests can already detect a pregnancy even if the woman is just a few days delayed in her menses. However, if the result is negative and pregnancy is still suspected, a repeat pregnancy test should be done. A negative pregnancy test may be the result of it being performed too early.

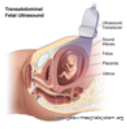
Clinical Care Manual for Midwives

1. **Detect and Date the pregnancy**
   In cases when the last menses cannot be established reliably (i.e. Woman is not sure, previously taking pills or DMPA, having abnormally long or short cycles), perform:



Bimanual exam : within the first 12 weeks AOG

Abdominal exam : AOG determined by the symphysis-fundic measurement



Ultrasound exam : reasonably accurate if AOG <24 weeks

A pregnancy can be dated in several ways. This is especially important in cases when the last menses cannot be reliably established (ex. Woman does not keep track of her menses, irregular menses, previous DMPA use, etc).

For pregnancy with AOG 12 weeks and earlier, a bimanual examination is sufficient to date a pregnancy. In a bimanual examination, the examiner palpates the uterus, including its size, and the adnexal structures. For more advanced pregnancies, AOG is determined via an abdominal examination, done by measuring the distance (in cm) between the symphysis and the fundus of the uterus (fundic height). A fundic height at the level of the umbilicus is approximately 20 weeks AOG.

However, an Ultrasound examination provides a more accurate dating of a pregnancy. Serial ultrasound is recommended and it can give a reasonably accurate data if it is started when the pregnancy is <24 weeks AOG.

Case 1

On physical examination, patient appears pale and nervous. She admits to having a mild headache but says it must have been caused by the heat during her trip to the clinic. She says headaches are normal for her, occurring occasionally the past few weeks, and relieved by bed rest.

Read the case and proceed to the next slide for the question.

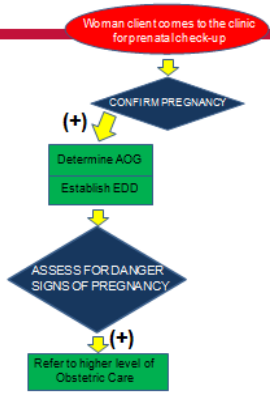
What would be your action?

A. Assess and examine patient quickly, send her home so she can rest
B. Prescribe prenatal vitamins and meds for the headache, send her home so she can rest
C. Do rapid assessment, request for laboratory examinations and refer to higher level of service
D. Refer to higher level of service
E. None of the above.

Solicit participants' opinions, then explain the correct answer, as follows:

Any client that comes into the clinic must be assessed. As part of a prenatal check-up, laboratory examinations can be requested (complete blood count (CBC), blood typing, urinalysis). Because the client complains of a headache, she should be referred to the midwife's back-up Ob-Gyne or to a facility with a higher level of service. Although the client claims the headaches are 'normal' for her, she should still be referred for evaluation and proper management.

Prenatal Consultation



After establishing the presence of the pregnancy and determining the AOG and EDD, the client must be examined. Whether it will be rapid assessment or a complete physical examination, the client must be assessed for the presence of any of the Danger signs of pregnancy. Client must be referred to a physician or to a facility with a higher level of service if she presents with any of the identified danger signs of pregnancy.

Clinical Care Manual for Midwives

2. Do an "Immediate Assessment"

Observe or ask about the following danger signs of pregnancy. If any of these are present, the woman will have to be referred immediately to a higher level of service (e.g. OB) and facility (e.g. Hosp)

- Swelling of legs, hands, &/or face
- Severe headache, dizziness, blurring of vision
- Vaginal bleeding
- Foul vaginal discharge
- Watery vaginal discharge
- Pallor or anemia
- Fever and chills
- Vomiting
- Rapid or difficult breathing
- Severe abdominal pain
- Painful urination
- Convulsions
- Absence or reduced fetal movements
- Hypertension or BP>140/90
- Abnormal lab results: CBC, blood sugar, etc.

Whether a rapid assessment or a complete history and physical examination, the client must be assessed immediately. If evaluation of the client reveals the presence of any of the 'danger signs' of pregnancy, she should be referred immediately to the back-up Obstetrician or to a facility with a higher level of service (usually, a hospital).

Workshop: In Groups

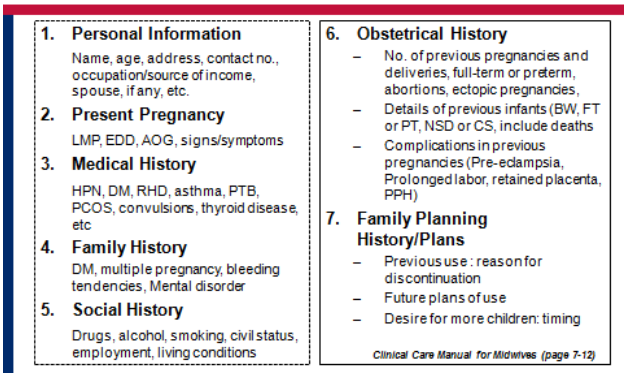
A pregnancy test done at the clinic shows a "positive result." Your bimanual examination reveals the uterus to be 3 months size. The patient agrees to the referral to the Obstetrician but reiterates that, if possible, she wants to continue prenatal care with you.

Make a checklist of all the items / data that you would try to elicit from the patient during this first prenatal visit.

It is important that a complete history be obtained during the first prenatal check-up of the client. What information should a midwife elicit from the client?

(Facilitator can go around the room to get answers from the participants).

Basic Prenatal Care



In basic prenatal care, information regarding the client must be elicited as completely as possible.

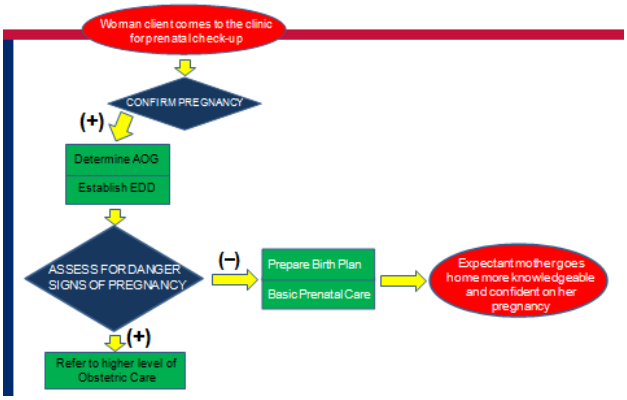
1. Personal Information – to establish rapport with the woman and to ensure she does not fall within the 'high-risk' category
2. Present Pregnancy – be sure to ask the client about their signs and symptoms;
3. Medical History – some medical conditions may become worse during a pregnancy, and thus their presence must be determined;
4. Family History- a history of a medical condition in immediate family members increases the risk of these conditions in the woman and her child;
5. Social History such as smoking and alcohol intake has the possibility of causing congenital abnormalities and/or intrauterine growth retardation;
6. Obstetric History – can indicate the presence of possible pregnancy complications and/or any other factors that may put the woman at risk during the pregnancy or during labor and delivery;
7. Family Planning History & Plans – information can be used to counsel the couple on family planning, based on their needs and their family planning knowledge and experience.

Basic Prenatal Care- Continued

	1st Visit	Subsequent Visits	Significance
B. Physical Examination			
HEENT	√	√	
Heart & Lungs	√	√	
Abdomen	√	√	
C. Laboratory Examination			
Hemoglobin	√		
Blood type	√		
Urinalysis	√		
Ask about episodes of fever, chills, pain or burning sensation	√	√	
D. Schedule of Return Visit	√	√	

The first prenatal visit entails obtaining a complete history and doing a complete physical examination on the client. Some basic laboratory examinations (CBC, blood type, urinalysis) are also requested. In subsequent visits, a woman also needs to undergo physical examination. For every visit, a woman must be informed of her future schedule for the return or next visit to ensure continuity of prenatal care.

Prenatal Consultation



In instances when the woman has been assessed and has none of the danger signs of pregnancy, a midwife can proceed to do the basic prenatal care as previously discussed. During the first prenatal visit, a birth plan should be prepared and, in succeeding visits, should be reviewed.

Details of a birth plan will be discussed in the next module, "Clinic Operations Standards Manual / Clinic Forms."

In the management of this patient, what will you include?

A. Request for laboratory exams
B. Give Tetanus Toxoid, if necessary
C. Prescribe Iron/folate supplements
D. A and C only
E. All of the above

Read the question on the slide and solicit answers from participants. Explain the correct answer as follows:

The correct answer is 'E'. All of the Above.

- Basic laboratory examinations such as CBC, blood type, and urinalysis are usually requested during the 1st prenatal visit and repeated in succeeding visits, if necessary.

- Tetanus Toxoid (TT) vaccine must be provided, based on the woman's immunization status. It is important that a pregnant woman receives immunization against tetanus so her infant can be protected. TT can be given at first contact or as early as possible during the pregnancy (DOH AO No. 25, series of 1997).

- Iron 60mg and Folate 400mcg should be prescribed once daily, to be taken by mouth, starting at the first trimester of pregnancy. It is recommended that the client receives 180 tablets of iron during the pregnancy.

Clinical Care Manual for Midwives

Tetanus Toxoid Immunization: Schedule

Dosage	Given	Period of Protection
1st dose	As early as possible during pregnancy	None
2nd dose	1 month after the 1st dose	3 years after 1st dose
3rd dose	At least 6 months after the 2nd dose	5 years
4th dose	At least 1 year after the 3rd dose	10 years
5th dose	At least 1 year after the 4th dose	Lifetime

Clinical Care Manual for Midwives (page 16 and 63)

Iron / Folate

- Give iron 60mg + folate 400mcg to be taken by mouth once daily for six months starting on the first trimester (or as early as possible)
- Possible side effects include black stools, constipation, and nausea

Clinical Care Manual for Midwives (page 16)

TT vaccine must be provided based on the woman's immunization status. It is important that a pregnant woman receives immunization against tetanus so her infant can be protected. TT can be given at first contact or as early as possible during the pregnancy (DOH AO No. 25, series of 1997). In the DOH Field Health Service Information System, health care facilities are required to report on the number of mothers receiving TT vaccine. If the mother has complete immunization against tetanus, her babies will be protected at birth.

Iron 60mg and Folate 400mcg should be prescribed once daily, to be taken by mouth, starting on the first trimester of pregnancy. Mothers should be advised to eat foods rich in Vitamin C to help the body absorb iron. Tea, coffee, and colas should be avoided as these inhibit iron absorption.

Return Visit – When to Schedule:

Match Patients in column A with their next scheduled visit (Column B)		
	A	B
A	1. Patient has BP = 150/90, 16 weeks AOG	A. 1 week after
C	2. Patient has BP = 110/70, 20 weeks AOG (1st visit)	B. 2 weeks after
B	3. Patient is 12 weeks AOG, pale, Hemoglobin=6.9 g/dl,	C. 1 month after
A	4. Patient with EDD = day of check-up	D. 2 months after
C or D	5. Patient is from far-flung barrio; 24 weeks AOG (2nd visit)	E. 3 months after

For every clinic visit, it is important that, before a client leaves, she is informed of her scheduled return visit. Although there is a recommended schedule of visits, the frequency of visits should be adjusted in special cases.

1. In clients with hypertension, refer to back-up medical doctor and as a follow-up, client should be instructed to return to the midwife one week after.

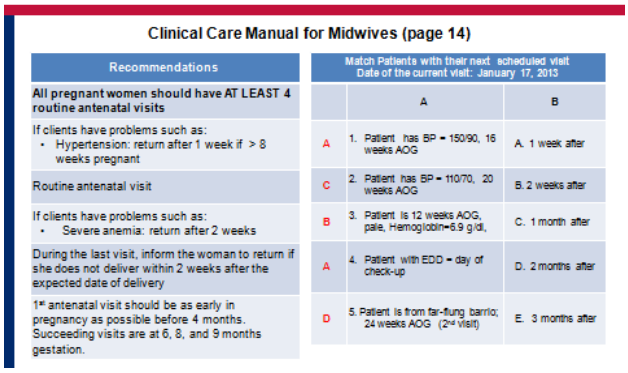
2. Each client should have at least four prenatal check-ups. Recommended schedule is one prenatal visit during the 1st trimester, one prenatal visit during the 2nd trimester, and two prenatal visits during the 3rd trimester of pregnancy.

3. Client has severe anemia. Client should be referred to a physician and follow-up with the midwife two weeks after.

4. If the client still does not deliver on her EDD, client must be required to come back after one week. It is recommended that a referral be done to the back-up Ob-Gyne for the evaluation and management of the client.

5. Clients from far-flung areas should have at least 4 prenatal visits. The 1-1-2 recommendation applies. The client in the case study is already in her 6th month of pregnancy so her next check-up should be in the 3rd trimester (7th or 8th month of pregnancy).

Return Visit – When to Schedule:



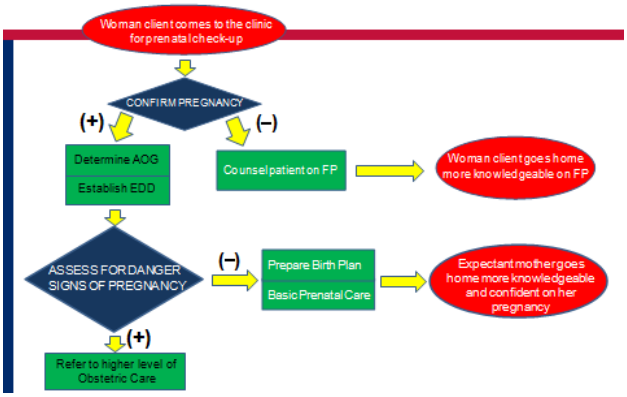
Clinical Care Manual for Midwives (page 14)

Recommendations	Match Patients with their next scheduled visit Date of the current visit: January 17, 2013		
		A	B
All pregnant women should have AT LEAST 4 routine antenatal visits			
If clients have problems such as: • Hypertension: return after 1 week if > 8 weeks pregnant	A	1. Patient has BP = 150/90, 16 weeks AOG	A. 1 week after
Routine antenatal visit	C	2. Patient has BP = 110/70, 20 weeks AOG	B. 2 weeks after
If clients have problems such as: • Severe anemia: return after 2 weeks	B	3. Patient is 12 weeks AOG, pale, Hemoglobin=6.9 g/dl,	C. 1 month after
During the last visit, inform the woman to return if she does not deliver within 2 weeks after the expected date of delivery	A	4. Patient with EDD = day of check-up	D. 2 months after
1st antenatal visit should be as early in pregnancy as possible before 4 months. Succeeding visits are at 6, 8, and 9 months gestation.	D	5. Patient is from far-flung barrio; 24 weeks AOG (2nd visit)	E. 3 months after

All pregnant women should have at least four (4) routine antenatal visits. First prenatal visit should be early in pregnancy, before 4 months age of gestation (1st trimester). Succeeding visits should include 1 prenatal check-up during the 2nd trimester and 2 prenatal check-ups during the 3rd trimester of the pregnancy.

During each prenatal visit, before the woman leaves the clinic, her return visit should already be scheduled. There are special cases when a woman would be required to come back at an earlier date than usual.

Patient with Unconfirmed Pregnancy



If a client comes into the clinic for prenatal check-up but pregnancy is not confirmed, client can be counselled on family planning, if appropriate. Any client who does not wish to get pregnant now or in the next few months/years can be advised on the different family planning methods, including their respective advantages and disadvantages. The client can then choose the method she desires.

With family planning counselling, it is expected that the woman/client goes home more knowledgeable on family planning.

Case 2

R.M., 34 years old, G2P1, came into the clinic complaining of labor pains since 1 hour ago. She appears fine. Upon examination, vital signs are as follows: BP=140/100, PR= 79/min, RR=21/min, Temp=37.0^{0}C. IE is 2-3cm.

Your initial assessment and management will be:

A. Patient is relatively normal; will admit and observe.
B. Patient is hypertensive; will refer to higher level of service.
C. Patient is hypertensive; will admit and observe.
D. Patient is fine; send home and advise to come back when in active labor
E. None of the above

Read the case then solicit participants' opinions. Discuss the correct answer, as follows:

The correct answer is 'B. Patient is hypertensive; will refer to higher level of service.'

The presence of any danger sign of pregnancy requires immediate referral. In this case, even though the woman appears fine, her blood pressure falls within the definition of hypertension (> 140/90) hence she should be referred immediately to the back-up Ob-Gyne or to a facility with a higher level of service.

DANGER SIGNS

- Bipedal edema, with pallor or hypertension
- Fetal heart rate <100 beats/min or >180 beats/min
- Blurred vision
- Breathing difficulty
- Severe headache
- BP ≥ 140/90 or
- Systolic BP < 90 mmg Hg

- Vaginal bleeding
- Temperature >38^{0}C
- Severe pallor
- Epigastric or abdominal pain
- Convulsions or unconsciousness
- Palpable umbilical cord in the birth canal or over the fetal head

The listed danger signs of pregnancy require immediate referral to the back-up Ob-Gyne or to a facility with a higher level of service. Should a woman present with any of these danger signs at any time during the pregnancy, referral is mandatory.

What will be your plan of action in the following emergency situations?

Match Column A with all applicable in Column B

	A	B
A,B,C, D,E	1. Vaginal bleeding with possible signs of impending shock	A. Start IVF, D_5LR or NSS
		B. Turn woman to her (L) side
A,B,C, E	2. Breathing Difficulty	C. Oxygen inhalation by mask or nasal cannula
B, E	3. High BP (≥140/90), with convulsions	D. Elevate legs
C, F	4. Fetal HR <100/min or >180/min, 2nd stage of labor, imminent delivery	E. Refer/ Transport immediately
F	5. Umbilical cord prolapse, cord pulsating, 2nd stage of labor	F. Deliver immediately

Clinical Care Manual for Midwives (page 19-20)

Ask the participants to match their decisions (Column B) with the scenario (Column A).

Emergency situations require immediate referral to a facility with a higher level of service. Midwives should not waste time. Transportation of the woman should be arranged immediately. However, while waiting for the transport vehicle to arrive and/or during the transport process itself, a midwife who is adequately trained on Basic Emergency Obstetric and Newborn Care can institute "first-aid" measures.

If the woman has vaginal bleeding with possible signs of impending shock, an intravenous fluid (IVF) line should be inserted to replace fluids. Improving oxygenation by turning the woman on her left side, giving oxygen inhalation by mask / nasal cannula, or elevating legs should be done. Client must immediately be referred / transported to a hospital.

For clients experiencing breathing difficulty, referral/transport must be done immediately. IVF line can be inserted for immediate administration of medicines in the hospital; oxygen can be administered and woman turned on her left side to improve oxygenation.

In eclamptic clients (with high blood pressure and with convulsions), the client can be turned to her side to prevent aspiration. Immediate referral is necessary. IV insertion would be difficult during the convulsive state.

In fetal distress and cord prolapse, baby should be delivered immediately. The baby has a better chance of survival if delivered and managed accordingly. Oxygen inhalation can be administered to improve oxygenation of the baby while in utero.

In cases of cord prolapse, deliver the baby if the woman is in the 2nd stage of labor, and there is imminent delivery. Turn her on her side to prevent aspiration. Immediate referral is necessary. Intravenous insertion would be difficult during the convulsive state.

In fetal distress and cord prolapse, baby should be delivered immediately. The baby has better chance of survival if delivered and managed accordingly. Oxygen inhalation can be administered to improve oxygenation of the baby while in utero.

In cases of cord prolapse, deliver the baby if in the 2nd stage of labor and there is imminent danger..

Which does NOT belong to the group?

A. Twin pregnancy
B. Preterm labor
C. History of forceps delivery in previous pregnancy
D. Face presentation
E. None of the above

All need to be referred to higher level of care (Obstetrician or a hospital)

Read the question on the slide and solicit answers from participants. Explain the correct answer, as follows:

The correct answer is 'E. None of the above.'

Twin pregnancy, preterm labour and face presentations can lead to a difficult/complicated delivery. History of forceps delivery in previous pregnancy is indicative of a previous difficult delivery which can possibly happen again in the present pregnancy. In all of these instances, the woman should be immediately referred to a higher level of care, either an Obstetrician and/or a hospital.

Stages and Phases of Labor

	Stage of Labor (1st, 2nd, 3rd)	Phase of Labor (latent or active; early or late)
A. Cervix fully dilated	2nd	Early / Late
B. Fundus gets firmer & rises in the abdomen	3rd	
C. Urge to push	2nd	Late
D. Dilatation rate at 1cm/hr	1st	Active
E. Cervix <4cm	1st	Latent
F. Fetal head visible	2nd	Late
G. Fetal descent begins	1st	Active
H. Cervix 4-9cm	1st	Active
I. Cord lengthens	3rd	
J. Small gush of bleeding per vagina	3rd	

There are three stages of labor. The 1st and 2nd stage of labor both have two different phases.

First Stage: The time from the onset or start of labor up to the time the cervix is completely dilated to 10 cm. Latent Phase: Begins when the cervix starts to dilate; cervix is <4 cms dilated; contractions are mild, occurring every 15-20 minutes, then progress to become stronger and more frequent; lasts approximately 8 hours. Active Phase: Cervix is dilated 4-9cms; rate of dilatation is 1 cm/hour; fetal descent begins; contractions are more intense, more regular, and lasts longer

Second Stage: From the time the cervix is fully dilated (10cm) to the time the baby is delivered. Early Phase (non-expulsive): Cervix is fully dilated (10cm); fetal descent continues; mother has no urge to push. Late Phase (expulsive): Cervix is fully dilated; fetal head reaches the pelvic floor; woman has the urge to push; perineum is distending; and fetal head is visible

Third Stage: Delivery of the placenta; fundus gets firmer and rises in the abdomen; shape of the fundus changes; cord lengthens; small gush of blood from vagina.

Management of Labor

Check (√) the appropriate management for the different stages of labor:

	1st	2nd	3rd
A. Monitor contractions fetal heart rate (FHR)	√	√	
B. Monitor cervical dilatation	√	√	
C. Monitor for rupture of membranes (BOW)	√	√	
D. Monitor for danger signs	√	√	√
E. Record findings in the partograph	√	√	√
F. Monitor BP, PR	√	√	√
G. Monitor for vaginal bleeding	√	√	√
H. Administer uterotonic drug			√
I. Fundal massage			√
J. Encourage woman to push		√	

The midwife should continuously monitor a woman during labor and delivery. In general, the midwife must monitor for the following:

- any danger sign of pregnancy
- uterine contractions (frequency, intensity, and duration of contractions)
- cervical dilatation
- fetal heart rate
- descent of the fetal head
- rupture of membranes
- vital signs
- any form of vaginal bleeding

It is important to record all monitored findings. The use of the partograph is mandatory. With the partograph, the progress of labor is monitored and it gives alert as to when clients should be referred to a facility with a higher level of service.

Essential Intrapartum & Newborn Care

Intrapartum Period	Essential Newborn Care
• Continuous maternal support by having a companion of choice during labor and delivery • Freedom of movement during labor, monitoring progress of labor using the partograph • Non-drug pain relief before offering labor anesthesia • Position of choice during labor and delivery • Spontaneous pushing in a semi-upright position • Non-routine episiotomy, and • Active management of the third stage of labor (AMTSL).	Four core steps were recommended in a time bound sequence: 1. Immediate and thorough drying of the newborn 2. Early skin-to-skin contact 3. Properly-timed clamping and cutting of the umbilical cord 4. Non-separation of newborn and mother for early breastfeeding

http://www.wpro.who.int/philippines/areas/maternal_child_nutrition/newborn_mother_careservi/index.html. Accessed February 3, 2013

Essential Intrapartum and Newborn Care or EINC: a combination of the care / management of the woman during labor & delivery and of the newborn, immediately after delivery.

During the intrapartum period, it is important that the woman is made to feel confident and comfortable during the birthing process. Encourage support from the birth companion throughout labor. Describe to the birth companion what he/she should do and ask the birth companion to call for help, if needed. Woman must be encouraged to walk or to move freely during the first stage of labor. Allow her to choose her preferred position (left lateral, squatting, kneeling, etc. for each stage of labor and delivery. Pain and discomfort relief through other means should be offered before any drug therapy. Suggest change of position, mobility, back massage by companion, or breathing techniques, etc. as these can help alleviate the discomfort.

As part also of the care during the intrapartum period, the use of episiotomy should not be made routine, unless really necessary. WHO recommends that Active Management of the Third Stage of Labor (AMSTL) be practiced in all pregnancies because of the overwhelming evidence proving that reduces the risk of postpartum hemorrhage.

Essential newborn care is defined by the performance of the four core steps recommended to be performed in a time-bound sequence. This will later be discussed further.

Essential Intrapartum and Newborn Care

AMSTL and ENC : Number in correct sequence.

_3_ palpate abdomen (to exclude another baby)
_8_ catch placenta with both hands
_5_ clamp cord, tie, and cut (delayed clamping)
_7_ controlled cord traction & counter traction to the uterus
_6_ await strong uterine contractions
_4_ administer Oxytocin 10 IU intramuscularly
_9_ apply fundal pressure (gentle uterine massage)
_10_ check if placenta and membranes are complete
_1_ drying of the baby
_2_ Skin-to-skin contact
_12_ Initiation of Breastfeeding
_11_ Non-separation of Mother and Newborn

EINC consists of the performance of both the AMSTL and the essential newborn care. However, these two processes need to be intertwined for the proper sequencing of events.

Ask the participants to number the steps in the correct sequence; starting from the time the baby is delivered.

1-2. Immediately after delivery of the baby, dry the newborn for at least 30 seconds without removing the vernix. Place baby on the mother's abdomen ensuring immediate skin-to-skin contact. Remove wet cloth and place a dry blanket at baby's back and a bonnet on its head to keep the baby warm.

3. As part of the AMSTL protocol, within one minute of delivery of the baby, the abdomen must be palpated to exclude another baby.

4. Give the mother 10 IU oxytocin intramuscularly as soon as it is determined that there is no other baby.

5. Wait until the cord stops pulsating or 2-3 minutes after the baby's birth – whichever – comes first then tightly tie around the cord at 2 cm from the baby's abdomen and 3cm from the first tie. Cut between the two ties with sterile scissors.

6, 7, 8. Await strong uterine contractions and deliver placenta by controlled cord traction. Catch the placenta with both hands to prevent tearing of the membranes.

9. Apply fundal massage after delivery of the placenta to ensure that uterus is contracted and mother is not bleeding.

10. Check if the placenta and membranes are complete by observing that there are no gaps or spaces that may indicate missing placental parts. Do not manually explore the uterus for retained placental fragments.

11-12. The last two steps in time-bound newborn care - The non-separation of mother and newborn in preparation for initiation of breastfeeding.

Monitoring Immediately Postpartum

- Check uterus every 5 mins to make sure it is contracted and there is no bleeding
- Check perineum, vaginal wall ,and vulva for tears
- Estimate and record blood loss
- Clean the woman and area beneath her
- Monitor & assess woman up to 6 hours after delivery
  - Vital signs
  - Watch out for vaginal bleeding
  - Check uterine firmness: q 15mins x 2 hrs; then q 30mins x 1 hr; the q 3hrs
- Monitor neonatal well-being
- Continue breastfeeding initiation

The midwife should continue monitoring the client after delivery. Monitoring should be done regularly to ensure that there is no bleeding. Uterus must be contracted and there should be NO vaginal, perineal or vulavar tears which can all contribute to postpartum haemorrhage.

Newborn baby needs to be checked and monitored. Midwife should encourage breastfeeding.

Neonatal Care

In a newborn, which is Normal and which is a danger sign?

	Normal	Danger Sign
A. Redness of the umbilical stump		√
B. Baby sucks and feeds at least 5x/day	√	
C. Respiratory Rate within 20-60 breaths/min	√	
D. Chest in-drawing		√
E. Bluish lips		√
F. Bluish hands and feet	√	
G. Swollen limbs and joints		√

Ask the participants to identify the normal or danger signs in a newborn.

Neonatal care includes early identification of danger signs such as redness of umbilical stump, chest in-drawing, bluish lips, swollen limbs and joints, jaundice, etc. Acrocyanosis or bluish hands and feet are caused by decreased blood circulation in the extremities. In newborn infants, this may be normal. However, if the cyanosis persists, then this becomes a danger sign.

Baby usually feeds every three hours or 8x a day. However, because of sleeping times, the frequency may be reduced. As long as the baby sucks vigorously, feeding frequency of at least 5x a day is acceptable.

Components of Maternal Postpartum Care

- Breastfeeding and breast care
- Family Planning
- Nutritional Support
- Hygienic Practices/Prevention of Infection
- Rest and Activity
- Sexual Relations and Safer Sex
- Immunizations and other preventive measures

There are several components in maternal postpartum care. Mothers should be advised on breastfeeding and breast care, family planning, nutrition, hygienic practices for herself and her baby, prevention of infection, necessary rest and allowable activities, sex practices and immunizations, etc.

Because of time constraints, these will be discussed briefly in the next slides.

Breastfeeding and Breast Care

- Exclusive breastfeeding for 1st 6 months
- Breastfeeding on demand (q 2-3hrs; 8-12x per 24 hrs)
- Use both breasts / feeding
- Adequate input ensured if urine output is ≥ 6x/day (2-7 days after birth)
- Get adequate rest & sleep
- Extra food & fluid intake
- Use cotton bra or breast binder
- Keep nipples clean and dry (no soap)

Family Planning

Methods for Women who plan to BREASTFEED	
Immediately after delivery	• Lactational Amenorrhea Method (LAM) • Condom • Female Sterilization (BTL) • IUD
6 weeks after delivery	• Progestin-only Pills (POP) • Progestin-only Injectables
6 months after delivery	• Fertility-based awareness methods • Combined oral contraceptives (COC)

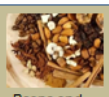
Methods for Women who CANNOT Breastfeed	
Immediately after delivery	• Condom • Progestin-only Pills (POP) • Progestin-only Injectables • Female Sterilization (BTL) • IUD
3 weeks after delivery (Day 21)	• Combined Oral Contraceptives

Family Planning should be discussed with the client. Various family planning options should be presented to the client to allow her to decide the method of her choice.

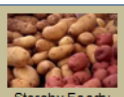
There is a difference in the family planning options between mothers who are breastfeeding their infants and those who are not.

Nutritional Support

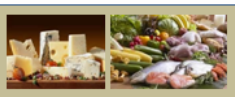
All women should eat a balanced diet



Beans and Nuts



Starchy Foods: potatoes, cassava, maize, cereals, rice



Animal products: meat, dairy products, fruits, vegetables

Other recommended food:

Iron: red meat, liver, eggs, peanuts, lentils, shellfish, dark green leafy vegetables

- Vitamin A: liver, milk products, eggs, sweet potatoes, pumpkin, carrots, papaya
- Calcium: milk, dark green leafy vegetables, shrimp, dried fish, beans, lentils
- Magnesium: cereal, dark green leafy vegetables, seafood, nuts
- Vitamin C: oranges or other citrus fruits, tomatoes

Avoid coffee or tea and calcium supplements as they inhibit iron absorption.

It is imperative that mothers receive adequate nutrition. It is recommended that they have intake of iron, vitamin A, calcium, magnesium, vitamin C, etc., which can be derived from food. Examples are cited in the slide.

Mothers should be advised against drinking coffee or tea and calcium supplements during the postpartum period as these inhibit iron absorption

Components of Maternal Postpartum Care

- **Self-care and other healthy practices**
  - Hygiene
  - Sexual relations and safer sex
  - Rest and activity
  - Newborn care
- **Immunizations and other preventive measures**
  - Tetanus toxoid immunizations (0, 1mo, 6mo, 1yr, 1yr)
  - Iron 60mg / folate 400mcg (once-daily for 3 months)
  - Intermittent preventive treatment for malaria (in endemic areas)
  - Vitamin A supplementation (postpartum)
- **Early and exclusive breastfeeding**

It is ideal that mothers resume sexual relations after 6 weeks postpartum. However, in some circumstances, when desired, sexual contact should be resumed 2 weeks postpartum, at the earliest.

Immunizations which have not been completed before and during pregnancy (ex. tetanus toxoid) should be continued after delivery. Iron supplementation must also be continued. It is now recommended that mothers receive vitamin A supplementation during the postpartum period instead of during pregnancy as previously advocated.

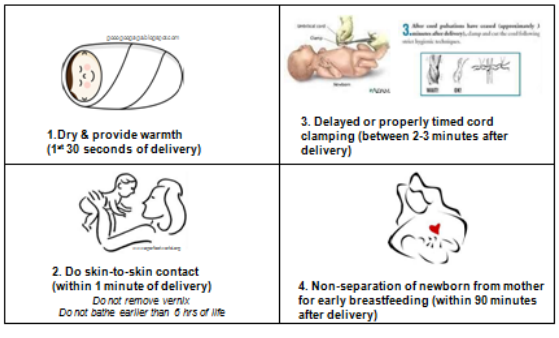
Ask the participants if they have any questions on clinical care before proceeding to the next section on Newborn Care.

NEWBORN CARE

QUALITY ASSURANCE PACKAGE FOR MIDWIVES WORKSHOP 2013

Immediate Newborn Care

Four Essential Time-Bound Interventions



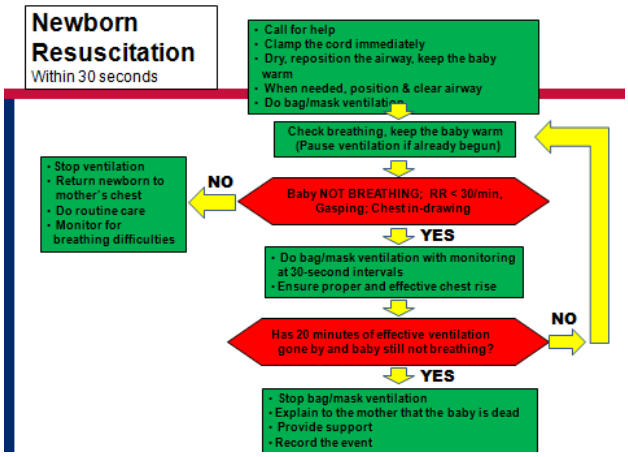
Immediate Newborn Care consists of four essential time-bound interventions:

1. Dry and provide warmth to the newborn. This should be done within the first 30 second after delivery. Use a clean, dry cloth to thoroughly dry the baby. Do not wipe off the vernix. Do a quick check of the newborn's breathing while drying.

2. Do skin-to-skin contact. Within one minute after delivery, place the newborn prone on the mother's abdomen or chest skin-to-skin. Cover newborn's back with a dry, warm blanket and put a bonnet on the baby's head. Avoid any manipulation such as routine suctioning that may cause trauma or introduce infection. Do not separate the baby from the mother.

3. Delayed or properly timed cord clamping. Wait for the cord pulsations to stop or 2-3 minutes after the baby's birth – whichever comes first – before clamping and cutting the cord. Remove the 1st set of gloves before handling the cord.

4. Non-separation of the newborn from mother for early breastfeeding. Within 30 minutes after delivery. Initiate breastfeeding as soon as the newborn shows signs of readiness to breastfeed, i.e., opening of the mouth, licking, rooting, etc. Do not do the following BEFORE the newborn's 1st breastfeeding session: eye care, Vit K injection, immunization, weighing, measurements, etc.



There may be instances when a midwife needs to resuscitate a newborn. It is vitally important that she undergoes training for this. When necessary, newborn resuscitation is started within 30 seconds after delivery.

Midwife should call for help, clamp cord immediately, re-position the baby to clear airway, and do bag/mask ventilation. Check breathing periodically. If baby starts to breathe, ventilation must be stopped and routine newborn care instituted. If baby does not breathe, continue to do the ventilation for up to 20 minutes.

Should there still be no breathing, stop ventilation, explain to the mother that the baby is dead, provide support and record the event. If the baby starts breathing at any time during the resuscitation, stop the ventilation and start routine newborn care.

Newborn Care

Which of the following is true, 90 minutes after delivery– time of discharge?

A. Support for breastfeeding: unrestricted, per demand, day and night; exclusive
B. Look or monitor for jaundice and infection
C. Can discharge mother and baby 10 hours after delivery
D. A and B only *(discharge should NOT be earlier than 12 hours after delivery)*
E. All of the above

Support exclusive breastfeeding on demand day and night. Assess breastfeeding in every baby before planning for discharge. Advise mother to alert the midwife if baby has breastfeeding difficulty.

Look for danger signs such as jaundice, chest in-drawing, fever, infected umbilical cord, etc. Refer immediately if jaundice occurs on the face of a <24 hour old newborn and on palms and soles of an infant > 24 hours old.

Plan to discharge when baby is breastfeeding well, there is no fever, baby has no breathing difficulty, and when mother is able and is confident in caring for her baby. Properly advise the mother prior to discharge. Mothers should not be discharged earlier than 12 hours after delivery.

Postpartum Visits

When will you schedule a woman's 1st, 2nd, 3rd postpartum visits?

1st Visit:	24 hours postpartum (home visit by midwife / check- up in BH)
2nd Visit:	Within 7 days postpartum (home visit by midwife)
3rd Visit:	6 weeks postpartum (clinic visit by patient)

It is important that mothers know when they should return for their postpartum visits. The postpartum mother must be checked 24 hours after delivery. This should be done at the birthing home prior to discharge or, if the mother has already been discharged, at home through a visit by the midwife.

2nd postpartum visit is within seven days after delivery. This is through a home visit by the midwife.

Mothers should be encouraged to come back to the clinic at 6 weeks postpartum for a check-up and, if possible, for family planning counselling.

Clinical Care Manual for Midwives

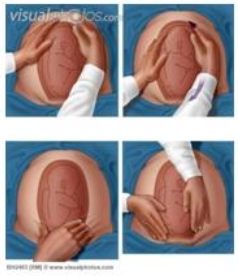
Section 2: Special Procedures

Special procedures cited are only for review. Only midwives who are trained on these procedures should attempt them, and only if necessary.

Abdominal Examination

FH Measurement

Leopold's Manuever



Examination of the abdomen is performed in the following way: inspection, measurement, palpation, and auscultation.

Leopold's maneuver is performed after 24 weeks AOG when the fetal outline can already be palpated.

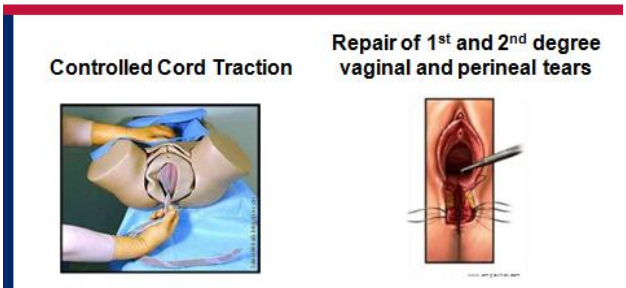
First Manuever – This determines the fetal part that is located at the upper fundus. The fetal head is hard, firm and round while the buttocks feel softer, symmetric and have small bony processes.

Second Manuever – This determines the location of the fetal back. The fetal back will feel firm and smooth while fetal extremities (arms, legs, etc) should feel like small irregularities and small protrusions.

Third Maneuver – This determines the fetal part lying above the inlet or lower abdomen. This maneuver should yield the opposite information and validate the findings of the first maneuver.

Fourth Maneuver – This determines the part of the fetal head that is presenting.

Special Procedures

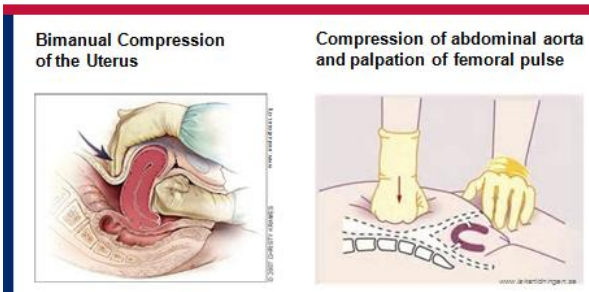


Midwives need to be trained on controlled cord traction and repair of vaginal and perineal repairs. These procedures, if not done properly, can lead to more serious consequences.

There are four degrees of tears that can occur during delivery;

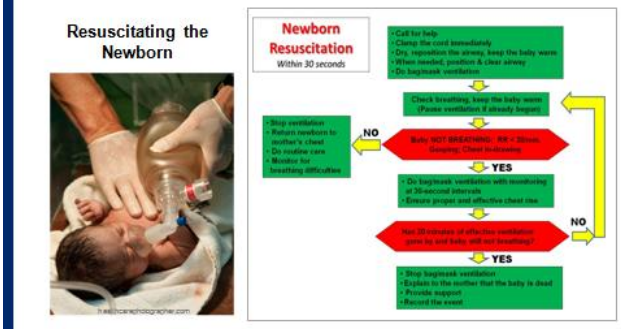
- First degree – involves vaginal mucosa and connective tissues
- Second degree - involves vaginal mucosa, connective tissues and underlying muscles
- Third degree – involves complete transection of the anal sphincter
- Fourth degree – involve the rectal mucosa
- Midwives are allowed to repair first and second degree perineal tears only.

Special Procedures - For Bleeding



Bimanual Compression of the uterus and compression of the abdominal aorta are procedures used to control profuse uterine bleeding during the transportation of the woman to the hospital.

Special Procedures- Newborn



Resuscitation of the newborn should be started if the newborn is:

- Completely floppy or limp and not breathing before 30 minutes of drying, and
- Not breathing or is gasping after 30 seconds of drying

Special Procedures-Newborn

Newborn Screening

Heel prick method is used. Do not puncture the following sites: arch of heel, swollen area; previously punctured area, and fingers.

Summary

- Clinical Care Manual of Midwives gives a comprehensive discussion of the management of a woman during pregnancy & delivery and it describes the necessary management of the newborn infant.
- Special procedures are also described to guide the midwives in their clinical practice.
- It is hoped that the presence of the manual can improve and sustain the quality of practice of practicing midwives.

SECTION 2
Clinical Operation Standards Manual

Section 2: Clinic Operation Standards Manual

Duration: 3.5 hours

- Lecture – 30 minutes
- Group Work / Case Study – 1.5 hours
- Discussion and review of the Clinic Forms – 1.5 hours

Objectives: At the end of the session, the participants will be knowledgeable on:

1. Standard Operating Procedure in a birthing home
   a. Guidelines for the professional midwife as she performs various clinic tasks such as outpatient consultations, admissions, infection prevention practices, referral systems, waste management
2. Standard Clinic Forms
   a. Different forms for recording patients' data
   b. Accurately and completely filling-out of the clinic forms

Materials Needed:

- QAP Manual for Midwives – Section 2
- Hard copy of the Standard Clinic Forms culled from the QAP Manual – Section 2
- Tarpaulins of each of the Standard Clinic Forms
  - Form 1, Form 2A and 2B – size 35" x 54"
  - Form 2C, 2D, 2E, Form 3, Form 4, Form 5 – size 35" x 48"
- Hard copy of the Partograph (Form 2D)
- Washable pentel pens (can be obtained from the children's section of the bookstore; do not use whiteboard marker as this cannot be erased when used on tarpaulin)

Methodology:

- Lecture
- Group discussion / Case study
- Plenary discussion

Process:

1. Give the objectives of the session to the participants.

2. For the part on Standard Operating Procedures,
   a. Briefly discuss the Standard Operating Procedures in a birthing home, ex. GATHER approach, outpatient consultations, admission cases, postpartum care, emergency cases, etc.
   b. Discuss the proper sequence of cleaning/sterilizing instruments to control infection, and
   c. Emphasize the need for proper waste management.

3. For the part on Standard Clinic Forms
   a. Divide the participants into four groups.

b. Each group will be given a case study. Ask the participants to discuss and decide what clinic forms they will use for the particular case.
c. From the available tarpaulins (enlarged replica of the standard clinic forms), the group retrieves the appropriate clinic form/s for their case.
d. With the facilitator acting as the client, the group does the interview and accomplishes the clinic form/s chosen. Remind the groups to completely and accurately fill-in the clinic form/s.

4. Plenary Discussion of the Group Work / Case Study
    a. Read each case; ask the corresponding group the following:
        - What was/were the clinic form/s used?
        - Any challenge encountered during the filling-in of the form/s?
        - Request facilitator/client to give his/her comments about the group
    b. Review each of the accomplished clinic form; facilitators shall give comments and corrections, where and when needed.
        - Were the entries technically correct?
        - Were the clinical terms used accurate?
        - Were the forms completely filed up? Ex. date and time of admission
        - Were the entries legible enough?
        - Is the partograph complete?
        - Please review the Leopold's maneuver

PowerPoint Slides

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Section 2

Clinic Operation Standards Manual

Section 2: The Clinic Operation Standards Manual

Part 1: Standard Operating Procedures

- Guidelines for the professional midwife as she performs various clinic tasks such as outpatient consultations, admissions, infection prevention practices, referral systems, waste management

Part 2: Standard Clinic Forms

- Different forms for recording patients' data

GATHER Approach

G - Greet the client; welcome her; make her comfortable

A - Ask what you can do for her; get the History

T - Tell the relevant information

H - Help client

E - Explain what will be done

R - Refer to higher level of service, if necessary

(or in Out-patient cases, 'Return' visit schedule)

Standard Operating Procedures

- Greet client as she/he enters the clinic.
- Ask client what you can do for her/him.
- Ask if she/he is a new client or revisit client.

For new client:

- Prepare a clinical record
- Get the demographic data and record in the appropriate space in the clinical record.
- Get the weight, height, and vital signs and write down in the clinical record.

For revisit clients:

- Retrieve clinical record from file. Record retrieval shall take no longer than 3 minutes.
- Get the weight, height, and vital signs and write down in the clinical records

Standard Operating Procedures

OUTPATIENT CONSULTATIONS (Including FP Services)

- Ask client to have a seat and wait for her/his name to be called.
- If there is another client being attended to, refer the newly-arrived client to another trained midwife in the clinic, if available.
- If there are no other clients in the clinic, bring her/him and her/his record to the consultation room where privacy and confidentiality are observed.
- MW/service provider gets the medical history, obstetrical history, conduct physical examination, request for laboratory procedures if appropriate. Writes down all findings in the clinical record.
- Provide the service/s as appropriate, including necessary instructions and follow-up schedule.

Standard Operating Procedures

ADMISSION CASES: Labor, Delivery, Immediate Postpartum and Newborn Care

- Secure/retrieve client record.
- Admit client.
- Examine client and record findings in the record form.
- Monitor progress of labor using the Partograph.
- Transfer client to delivery room when baby's head gradually becomes visible at the vaginal opening during contraction of uterus.
- Deliver baby and manage newborn (ENC)
- Record all findings both for mother and baby in their respective clinical records.

Standard Operating Procedures

POSTPARTUM CARE (Within 6 Weeks After Delivery)

- Retrieve client record.
- Examine : Vital signs, weight, temperature, perineum, observe for vaginal discharge
- Advise: breastfeeding and breast care; Immunization, if not yet complete; cord care; washing or bathing baby
- Record all findings both for mother and baby in their respective clinical records.
- Schedule next follow-up visit

Private Sector Mobilization for Family Health

Emergency Cases

- Emergency case is directly brought to the consultation/examination room or the delivery room as the case maybe and is attended to immediately.
- File clinical records at the end of the day based on the filing system used by the facility.
- Refer client to back-up doctor or to a higher level facility for complications or for services not available in the facility using the two-way referral form.

Infection Control

1. Wash hands
2. Wear gloves
3. Follow aseptic procedures when giving injections
4. Do not 'recap' needles
5. Proper sequence for used instruments
   - Decontaminate: soak in 0.5% Chlorine solution x 10 mins
   - Clean: rinse and wash with detergent and clean water
   - Sterilize - Autoclave : 20-30 minutes
     Dry Heat : 60 minutes
     Chemical (Cidex): Soak for 8 hours
     OR High level Disinfection - Boiling : 20 minutes
     Steam : 20 minutes
     Chemical: Soak for 20 minutes

Waste Management

Ensure proper waste management

- Classify waste into general and medical waste
- Segregate and put in color-coded containers
- Use gloves during handling and wash hands after handling
- Do note store for more than 2 days
- Final disposal : general waste – collected by regular garbage collector; solid medical waste - buried or transported for off-site disposal by appropriate collector; liquid medical waste - poured down a sink, drain or flushable toilets

PART 2: STANDARD CLINIC FORMS

Forms Available

Form 1 – Family Planning Service Record
Form 2 –

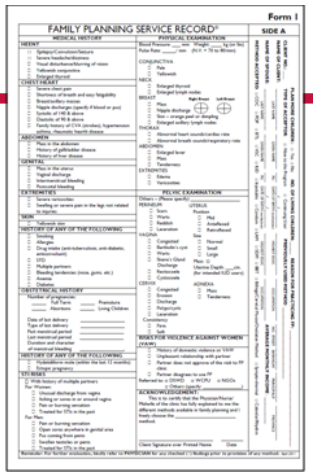
- 2A : Maternal Service Record (for first prenatal consultation)
- 2B : Maternal Birth Plan
- 2C : Maternal Service Record - Prenatal Care (for 2nd, 3rd, 4th, etc. prenatal visits
- 2D : Partograph
- 2E : Maternal Service Record – Postnatal Care

Form 3 – Pediatric Service Record
Form 4 – Outpatient Service Record
Form 5 – Referral Form

Note: Show the actual forms to the participants and explain accordingly as shown in the next slides. Hang the tarpaulins showing the standard clinic form.

FORM 1
FP Service Record

- Used to record information of FP services received by the client
- Accomplished for all clients who may either be new clients or transferees from other service outlets or clinics
- Parts: (1) front page – personal information, medical & obstetrical history; Physical examination; (2) back page – documenting succeeding visits and method used/supplies given

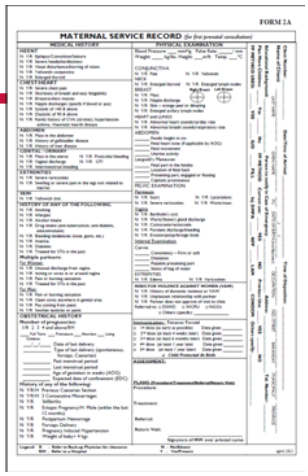


Form 2A :
Maternal Service Record
(for 1st prenatal consultation)

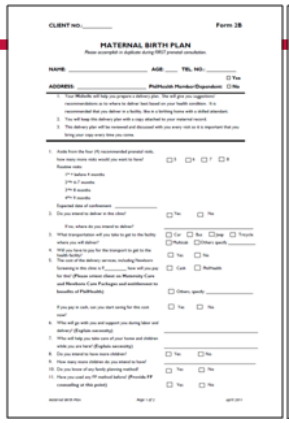
- Used for initial visit of a pregnant woman seeking prenatal services
- Contains personal information, family planning, medical & obstetrical history of the client, physical examination (including pelvic examination) findings
- Include's the midwife's assessment and plans on managing the case.

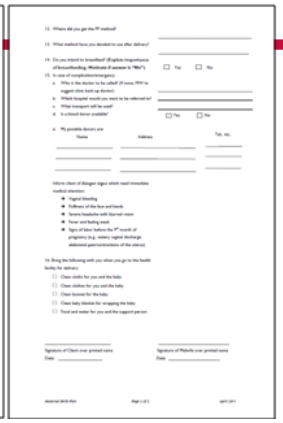
Legend:

Encircle N for NO/ABSENT if the client/patient has not had this condition or Y/R for YES/PRESENT if she has had this condition.



Form 2B : Maternal Birth Plan



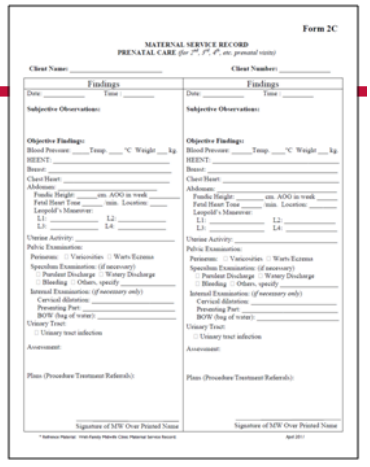


Maternal Birth Plan

- Always used together with the Prenatal Record
- Contains information needed by the midwife to help the pregnant woman plan for her safe delivery in a health facility or for immediate transport to a facility with a higher level of service, in cases of emergency

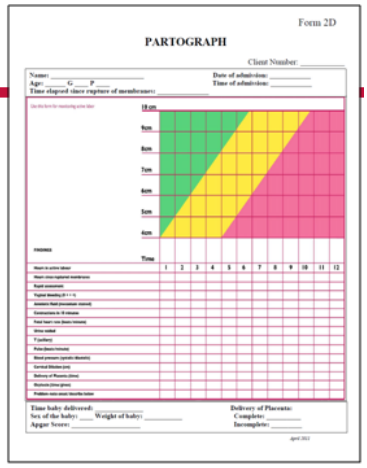
Form 2C : Maternal Service Record - Prenatal Care (for 2nd, 3rd, 4th, etc. prenatal visits)

- Used to record the second and all succeeding follow-up prenatal visits.
- Records the date and time the client came to the clinic, her subjective complaint, the findings of the midwife on physical examination, the assessment of the case, and the plan on how to manage the case.



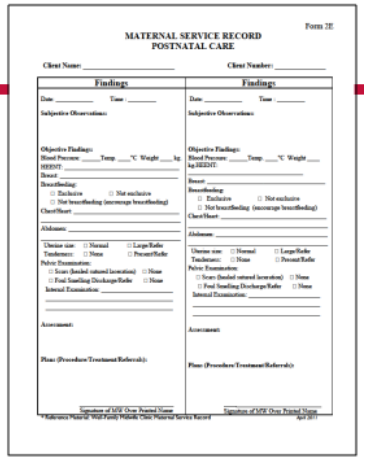
Form 2D :
Partograph

- Tool used in monitoring the progress of labor.
- Contains the information needed by the midwife to determine whether labor is progressing normally or if it is in need of a referral to a physician or a higher level facility.
- Includes information on the baby as well as the delivery of the placenta.



Form 2E : Maternal Service Record – Postnatal Care

- Used for clients who return to the facility or are visited at home within six weeks after delivery.
- The information contained in this form reflects the condition of the mother after delivery


Form 2E

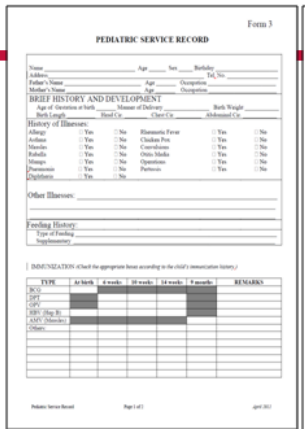
MATERNAL SERVICE RECORD
POSTNATAL CARE

Client Name: _____ Client Number: _____

Findings	Findings
Date: _____ Time: _____ Subjective Observations: Objective Findings: Blood Pressure: _____Temp ____°C Weight ____ kg HEENT: Breast: Breastfeeding: ☐ Exclusive ☐ Not exclusive ☐ Not breastfeeding (encourage breastfeeding) Chest/Heart: Abdomen: Uterine size: ☐ Normal ☐ Large/Refer Tenderness: ☐ None ☐ Present/Refer Pelvic Examination: ☐ Scars (healed sutured lacerations) ☐ None ☐ Foul Smelling Discharge/Refer ☐ None Internal Examination: Assessment: Plans (Procedure/Treatment/Referrals):	Date: _____ Time: _____ Subjective Observations: Objective Findings: Blood Pressure: _____Temp ____°C Weight ____ kg HEENT: Breast: Breastfeeding: ☐ Exclusive ☐ Not exclusive ☐ Not breastfeeding (encourage breastfeeding) Chest/Heart: Abdomen: Uterine size: ☐ Normal ☐ Large/Refer Tenderness: ☐ None ☐ Present/Refer Pelvic Examination: ☐ Scars (healed sutured lacerations) ☐ None ☐ Foul Smelling Discharge/Refer ☐ None Internal Examination: Assessment: Plans (Procedure/Treatment/Referrals):
Signature of MW Over Printed Name	Signature of MW Over Printed Name

* Reference: Philippine Well Family Midwife Clinic Maternal Service Record April 2011

Form 3 – Pediatric Service Record


Form 3

PEDIATRIC SERVICE RECORD

Name _____ Age _____ Sex _____ Birthday _____
Address: _____ TEL NO. _____
Father's Name _____ Age _____ Occupation _____
Mother's Name _____ Age _____ Occupation _____

BRIEF HISTORY AND DEVELOPMENT

Age of Gestation at birth _____ Manner of Delivery _____ Birth Weight _____
Birth Length _____ Head Cir. _____ Chest Cir. _____ Abdominal Cir. _____

History of Illnesses:

Allergy	☐ Yes ☐ No	Rheumatic Fever	☐ Yes ☐ No		
Asthma	☐ Yes ☐ No	Chicken Pox	☐ Yes ☐ No		
Measles	☐ Yes ☐ No	Convulsions	☐ Yes ☐ No		
Rubella	☐ Yes ☐ No	Otitis Media	☐ Yes ☐ No		
Mumps	☐ Yes ☐ No	Operations	☐ Yes ☐ No		
Pneumonia	☐ Yes ☐ No	Parlysis	☐ Yes ☐ No		
Diphtheria	☐ Yes ☐ No				

Other Illnesses: _____

Feeding History:
Type of Feeding _____
Supplementary _____

IMMUNIZATION (Check the appropriate boxes according to the child's immunization history.)

TYPE	At birth	4 weeks	10 weeks	14 weeks	9 months	REMARKS
BCG						
DPT						
OPV						
HBV (Hep B)						
AMV (Measles)						
Others						

Pediatric Service Record Page 1 of 2 April 2011


Form 3

PEDIATRIC SERVICE RECORD *continuation page*

Date/Time	Age	Weight	Height	Temp	Physical Findings/ Procedures	Impression/Treatment/ Interventions	Next Visit	Signature over printed name

Pediatric Service Record Page 2 of 2 April 2011

Pediatric Service Record

- The Pediatric Service Record Form is used for all pediatric cases seeking services in the clinic.
- The front page should contain personal data, information on the development of the baby, past medical history including immunizations given or scheduled to be given.
- The back portion of the form should have the information on the current status or condition of the patient.

Form 4 – Outpatient Service Record

- Used for clients needing services other than family planning, maternal or child care


Form 4

OUTPATIENT SERVICE RECORD

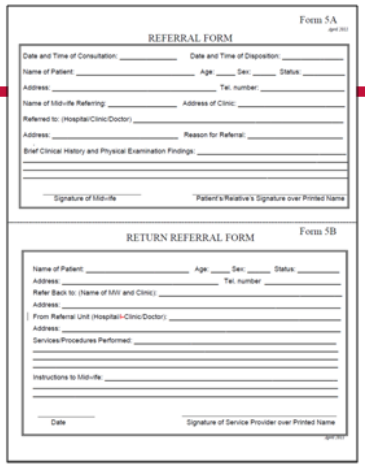
DATE SERVICE GIVEN	REMARKS • MEDICAL OBSERVATION • COMPLAINTS/ COMPLICATIONS • SERVICE RENDERED/PROCEDURES/ INTERVENTIONS DONE (laboratory examination, treatment, referrals, etc.) • OTHER IMPORTANT COMMENTS, IF ANY	NAME OF PROVIDER AND SIGNATURE	NEXT SERVICE DATE

FILL UP ALL BOXES AND BLANKS

* Adapted from the WFPIC Outpatient Service Record Page 1 of 1 April 2011

Form 5 – Referral Form

- Used for referrals to a back-up doctor, hospital, or to another clinic in the following situations:
  a. Emergency cases
  b. When complications arise in cases being handled in the clinic
  c. When services requested are not available in the clinic


Form 5A

REFERRAL FORM

Date and Time of Consultation: _____ Date and Time of Disposition: _____
Name of Patient: _____ Age: ____ Sex: ____ Status: _____
Address: _____ Tel. number: _____
Name of Midwife Referring: _____ Address of Clinic: _____
Referred to: (Hospital/Clinic/Doctor) _____
Address: _____ Reason for Referral: _____
Brief Clinical History and Physical Examination Findings: _____

Signature of Midwife Patient's Relative's Signature over Printed Name

Form 5B

RETURN REFERRAL FORM

Name of Patient: _____ Age: ____ Sex: ____ Status: _____
Address: _____ Tel. number _____
Refer Back to: (Name of MW and Clinic): _____
Address: _____
From Referral Unit (Hospital/Clinic/Doctor): _____
Address: _____
Services/Procedures Performed: _____
Instructions to Midwife: _____

Date Signature of Service Provider over Printed Name

CASE STUDIES

a. Divide the participants into four groups.
b. Each group will be given a case study. Ask the participants to discuss and decide what clinic forms they will use for the particular case.
c. From the available tarpaulins (enlarged replica of the standard clinic forms), the group retrieves the appropriate clinic form/s for their case.
d. With the facilitator acting as the client, the group does the interview and accomplishes the clinic form/s chosen. Remind the groups to completely and accurately fill-up the clinic form/s.

Scenario 1

C.Y. is a 23 year-old female, who delivered just 3 months ago. She came to the clinic because she does not want to get pregnant again in the next 4 years.

What form/s will be used?
What will be your plan of action?

Allow Group 1 to discuss the case and fill up the form(s).

Scenario 1

Form to be used:

- Family Planning Service Record (Form 1)

Plan of Action:

- Take the History: Basic information, medical history, obstetric history, social history (smoking, drug use, etc), STI risk factors
- Do a Physical Examination : HEENT, Breast, Heart, Lungs, extremities; Pelvic exam
- DO NOT FORGET: Have the patient sign to acknowledge acceptance of a particular method.
- REMINDER : Use this form for all FP clients, whether they accept a method or not (proof that FP counselling was done)

Show this slide after the group has explained their answers to the plenary.

Follow the same instructions in the proceeding cases.

Scenario 2

B.L., 33 year-old, came into the clinic for the first time. Pregnancy test done at home shows a positive result. LMP= August 5, 2013.

What will be your initial course of action?
What form/s will be used?

Scenario 2

What will be your initial course of action?

- Welcome the patient into the clinic
- Get basic information
- Confirm the pregnancy / determine AOG

What form/s will be used?

- If pregnancy is confirmed:
  - Maternal Service Record (Form 2A)
  - Maternal Birth Plan (Form 2B)

Scenario 3

G.S., 36 y/o, came to the clinic for check-up because of occasional dizziness. On History and Physical Examination, BP=140/90. Her menses is delayed for 5 days already but pregnancy test done at the clinic shows 'negative' result.

What would be your plan?
Fill out the correct form.

Scenario 3

What would be your plan?

- Complete the History & PE -→ OUTPATIENT SERVICE FORM
- Refer to back-up OB or back-up facility for evaluation & management of blood pressure --→ use REFERRAL FORM (Form 5)

Scenario 4

F.Y., 29 year-old, G2P1, 38 weeks AOG, came back to your clinic with uterine contractions. IE revealed the cervix to be 2-3cm dilated. BP=120/70, PR=65/min, RR=15/min, Temp=36.9^{0}C

What form/s will be used?
Maternal Service Record (Form 2C)
AND
Partograph (Form 2D)

Scenario 5

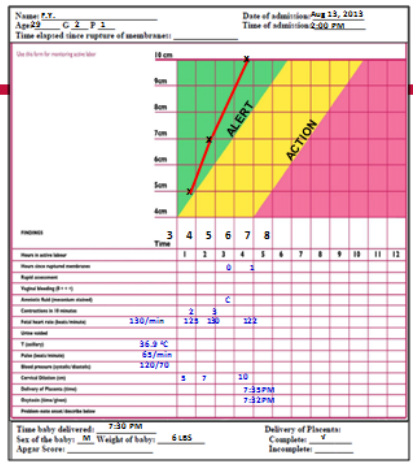
F.Y., 29 year-old, G2P1.

Time on admission: 2:00pm. On History, patients says she started having contractions about 3 hours ago. Vital signs: BP=120/70; PR=65/min; Temp=36.9ºC . On monitoring, patient has vaginal show, contractions are moderate in intensity, occurring every 15 minutes, cervix 3 cm, and FHB=130/min. After 2 hours in the clinic, repeat IE shows the cervix to be 5cm, contractions are moderate to severe in intensity, occurring every 5 minutes. FHB= 125/min. At 5pm, patient is already crying, with severe contractions occurring every 3 minutes, 40 seconds duration. Cervix is 7cm dilated. FHB= 130/min. At 6pm, BOW spontaneously ruptured , clear AF. At 7:00pm, patient is fully dilated, fetal head is visible at the perineum. FHB=122/min. Patient finally delivers a healthy baby boy at 7:30pm, wt=6lbs. Placenta was delivered after 5 minutes. Rest of the stay was uneventful.

ACCOMPLISH THE PARTOGRAPH FORM.

F.Y., 25y/o, G2P1;
Time on admission: 2:00pm.
Patient says she started having contractions about 3 hours ago.
Vital signs: BP=120/70; PR=65/min; Temp = 36.5 °C

- Patient has vaginal show, contractions are moderate in intensity, occurring every 15 minutes, cervix 3 cm, and FHB=130/min.
- After 2 hours in the clinic, repeat IE shows the cervix to be 5cm, contractions are moderate to severe in intensity, occurring every 5 minutes. FHB= 125/min.
- At 5pm, patient is already crying, with severe contractions occurring every 3 minutes, 40 seconds duration. Cervix is 7cm dilated. FHB= 130/min.
- At 6pm, BOW spontaneously ruptured, clear AF.
- At 7:00pm, patient is fully dilated, fetal head is visible at the perineum. FHB=122/min.
- Patient finally delivers a healthy baby boy at 7:30pm, wt=6lbs. Placenta was delivered after 5 minutes.
- Rest of the stay was uneventful.

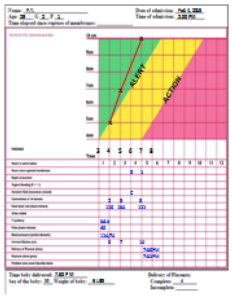


Question

Based on the partograph, was there a need for referral to the back-up Ob-Gyne or to a facility with a higher level of service?

The labor of the patient progressed normally. This is evidenced by the fact that her labor curve remained towards the LEFT of the ALERT LINE.

There was no need for referral.



REMINDERS : Use of Partograph

- Must be started only when the woman is in active labor (i.e. cervix dilatation is at least 4 cm, with at least 1 contraction in 10 mins which lasts for 20 seconds or longer)
- Plot the 'x' on the intersection of the vertical (cervical dilatation) and the horizontal line (time).
- Write the time when the IE was done on the line itself, not on the space after it.

Partograph

- The partograph is a tool to monitor the progress of labor.
- It gives an alert as to when patients should be referred to a facility with a higher level of service
- It does not give any indication of any risk factor that may be present before active labor starts

Partograph

- Competent use of the partograph can save lives by ensuring that labor is closely monitored and that life-threatening complications such as obstructed labor are identified and treated.
- To be deemed competent requires that a provider is capable of attending a normal labor and birth, performing abdominal examinations to determine fetal descent, and vaginal examinations to determine cervical dilation, and plotting this information on a graph.

Summary

- The proper decorum must be practiced in the clinics. Clients should be treated with care and confidentiality and their privacy ensured.
- History and PE must be done and each client must be managed accordingly.
- For labor and delivery, both mother and baby should be taken cared of and all findings for them should be recorded in their respective clinical records
- Forms, appropriate for each client's case, must be used.

SECTION 3
Monitoring Tool for Practicing Midwives

Section 3: Monitoring Tool for Midwives

Duration: 3 hours

- Lecture – 30 minutes
- Individual Self-Assessment - 1.5 hours
- Group Discussion – 1hour
- Plenary Discussion – 1 hour

Objectives: At the end of the session, the participants will be knowledgeable on:

- The QAP Self-Assessment tool and the Supervisors Monitoring Tool: what these are and how these are used
- How to review their own practice (self-assessment) – this determines the midwives' perspective of the level of quality of FP-MCH services they provide
- How to make improvements and/or seek outside assistance for concerns or issues identified (action planning/next steps).

Materials Needed: (culled from Section 3 of the QAP Toolkit for Midwives)

- Hard-copy of the Midwives Self-Assessment Tool - one per participant
- Hard-copy of the Summary of the self-assessment (what you do well; Areas where you can improve; remarks/recommendations) – 1 per group
- Hard copy of the Action Plan – 1 per group

Methodology:

- Lecture
- Individual Self-Assessment
- Group Discussion
- Plenary Discussion

Process:

1. Give the participants the session objectives and mechanics.

2. Give an overview of the components of Section 3 of the QAP toolkit (Midwives Portion and Supervisors Portion). Discuss the different components of the tools and how the self-assessment is done. Discuss briefly how the Supervisors monitoring tool is used and how it validates the midwife's self-assessment.

3. Divide the participants into smaller groups. It is recommended that midwives are grouped based on their area of practice.

4. Ask each participant to do a self-assessment using the Self-assessment tool.

5. After the individual self-assessment, let them review their findings and, as a group, have them identify common items: three common things that group members do well and three common areas that they need to improve upon. Encourage them to put in remarks/recommendations.

6. Ask each group to do the action planning, based on the items previously identified as needing improvement. Ask them to use the available form. (Annex F)

7. Convene all participants for a plenary discussion. Ask each group to present the results of their discussion and give a sample of their action planning. Give comments and, if necessary, give an example of how to fill up the action planning form.

PowerPoint Slides

Discussion

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Section 3

Monitoring Tool for Practicing Midewives

This section has two sets of tools – the midwife's self-assessment tools and the supervisor's monitoring tools.

Section 3: Monitoring Tool for Practicing Midwives

Part 1: Midwife Portion

- The self-assessment portion which determines the midwife's perspective of the level of quality of MCH/FP services she provides, and
- The action plan that addresses the things that need to be improved as identified in the self-assessment portion

Both tools have the same six components. (Read from slide.)

Midwife Self-Assessment Tool/ Supervisor's Monitoring Tool

Six (6) components that can be assessed:

1. Facility
2. Technical Competence
3. Continuity of Care
4. Management
5. Community Involvement
6. Business Practices (for private MWs)

Midwife Self-Assessment Tool

COMPONENT I: FACILITY	ASSESSMENT			
	Y	NI	NO	NA
Indicator A. Conditions/Amenities (12 items)				
Does the clinic have:				
1. A sign that bears the name of the facility?				
2. A big sign inside and outside the facility that lists the services offered?				
3. Sufficient seats for patients in a well-ventilated waiting area?				
Indicator B. Facility/Infrastructure (12 items)				
Does the clinic have:				
1. A generally clean environment?				
2. Adequate potable water?				
Indicator C. Educational Materials for Clients (3 items)				
Indicator D. Professional Appearance of Provider (1 item)				

Midwife should answer the questions:

- Yes, put a check (√) under Y in the answer column.
- Yes, but needs improvement, put a check (√) under NI in the answer column.
- No, put a check (√) under NO in the answer column. If the question is not applicable to your clinic, put a check (√) under NA.

Enumerate the different components and the corresponding indicators.

Midwife Self-Assessment Tool

COMPONENT II: TECHNICAL COMPETENCE	ASSESSMENT			
	Y	NI	NO	NA
Indicator A. Attitude, Behavior of Midwife (10 items)				
As a midwife, are you:				
1. Punctual?				
2. Cordial in greeting clients?				
Indicator B. Standards of Care (3 items)				
1. Do you have a copy of the most recent midwifery service delivery guidelines?				
2. Do you use the guidelines during your work?				
Indicator C. Basic Counseling Guidelines (6 items)				
Indicator D. Infection Prevention (10 items)				
Indicator E. Prenatal Care (21 items)				

Midwife Self-Assessment Tool

COMPONENT II: TECHNICAL COMPETENCE	ASSESSMENT			
	Y	NI	NO	NA
Indicator F. Obstetrical (Physical) Exam (11 items)				
Initial Visit				
Succeeding Visits				
Indicator G. Labor and Delivery (29 items)				
During Labor				
During Delivery				
Indicator H. Postpartum Care (11 items)				
Indicator I. FP: Info-giving and Counselling (16 items)				
Indicator J. STI: Patient Counselling and Education (1 item)				

Midwife Self-Assessment Tool

COMPONENT III: CONTINUITY OF CARE – 3 Indicators	ASSESSMENT			
	Y	NI	NO	NA
COMPONENT IV: MANAGEMENT				
Indicator A. Review of Practice, incl Review of Action Plan (5 items)				
Indicator B. Client Records (5 items)				
Indicator C. Supplies, Consumable Drugs, incl Vaccines (8 items)				
Indicator D. Medical Equipment, instruments, furniture (2 items)				
Indicator E. Information on Clinic Hours (3 items)				
COMPONENT V: COMMUNITY INVOLVEMENT				
Indicator A. Client Feedback (3 items)				
Indicator B. Advertising (2 items)				

Midwife Self-Assessment Tool

COMPONENT VI: BUSINESS PRACTICES (for private-practice MWs)	ASSESSMENT			
	Y	NI	NO	NA
Indicator A. SMART Goals (2 items)				
Indicator B. Financial Practices (6 items)				
Indicator C. Pricing and Collection System (3 items)				
Indicator D. Profitable Facility/Practice (1 item)				
Indicator E. Adequate Financing (3 items)				

Comments About the Facility (Component 1)

A. Record what you have done well in this section. Use the questions where you answered **Y** B. Record where you can improve. Use the questions where you answered **NI** or **NO**.	
	Remarks/Recommendations
What you do well:	
1. Provides clients with information to make health-related decisions	
2.	
3.	
Areas where you can improve:	
1. Tke measures to ensure that counselling sessions and physical examinations are not interrupted	Turn cellphone into silent mode/will not accept calls
2. Use every opportunity of a client's visit for maternal and child health services to discuss additional issues like FP	Not done because it is time-consuming

After answering the questions under each component, Midwife records the items that were done well (those rated as Y), and items that need improvement (those rated as NI and NO) in the comment boxes at the end of each component checklist.

Action Plan

Component	Indicator	Issues	Root causes (WHY)	Solutions	Action/ Next Steps	By Whom	By When	STATUS (After some time)
I. Facility	A.7	No contamination with	Not aware of the need	Prepare and always make available	Buy Zonrox, container; prepare	MW	Tomorrow	(1 week after) DONE

The Midwife should formulate an action plan with recommendations on how to address the items that have been identified as needing improvement (the items rated NI and NO).

This slide shows an example of an action plan.

Section 3: Monitoring Tool for Practicing Midwives

Part 2: Supervisor's Portion

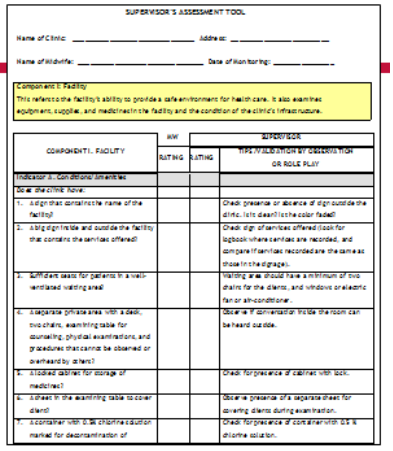
- To validate the midwife's assessment of her own quality of services and her facility; and
- Determines the midwife's progress in improving the quality of FP/MCH services based on her validated numerical scores and the action plans developed during the midwife's self-assessment portion.

The next slides explain the second set of tools – the monitoring tools to be used by supervisors.

The facilitator can opt to read or expound on what is written in the slides.

PART 1: Supervisor's Assessment Tool

- The same checklist as that of the midwife portion
- With helpful tips, reviewers, instructions, comments, etc.



SUPERVISOR'S ASSESSMENT TOOL

Name of Clinic: _____ Address: _____

Name of Midwife: _____ Date of Monitoring: _____

Component I: Facility

This refers to the facility's ability to provide a safe environment for health care. It also examines equipment, supplies, and medicines in the facility and the condition of the clinic's infrastructure.

COMPONENT I. FACILITY	MW RATING	SUPERVISOR RATING	SUPERVISOR TIPS/VALIDATION BY OBSERVATION OR ROLE PLAY
Indicator 1. Conditions/ Amenities			
Does the clinic have:			
1. A sign that contains the name of the facility?			Check: presence or absence of sign outside the clinic. Is it clean? Is the color faded?
2. A big sign inside and outside the facility that contains the services offered?			Check: sign of services offered (look for logbook where services are recorded, and compare if services recorded are the same as those in the signage).
3. Sufficient seats for patients in a well-ventilated waiting area?			Waiting area should have a minimum of two chairs for the clients, and windows or electric fan or air-conditioner.
4. A separate private area with a desk, two chairs, examining table for counseling, physical examinations, and procedures that cannot be observed or overheard by others?			Observe if conversation inside the room can be heard outside.
5. A locked cabinet for storage of medicines?			Check for presence of cabinet with lock.
6. A sheet in the examining table to cover client?			Observe presence of a separate sheet for covering clients during examination.
7. A container with 0.05 chlorine solution marked for decontamination of			Check for presence of container with 0.5 % chlorine solution.

Monitoring Tool For Practicing Midwives
Supervisor portion: Suggested Steps

Monitoring begins even before entering the lying-in clinic and meeting the midwife.

Observe the environment around the clinic for cleanliness.

Look at the clinic's signage, garbage provisions, waiting areas, look for a vehicle that may be the clinic's "ambulance", etc.

Monitoring Tool For Practicing Midwives
Supervisor portion: Suggested Steps

Observation IS the ideal and recommended method of monitoring. Therefore, the presence of patients in the clinic should NOT be a hindrance rather it is a facilitating factor in monitoring because then the supervisor can simply and quietly observe how the midwife conducts herself during a regular day at the clinic and then record her (the supervisor's) findings on the assessment tool.

Monitoring Tool For Practicing Midwives
Supervisor portion: Suggested Steps

It is advisable for the supervisor to **complete** all of his/her monitoring tasks **BEFORE** asking for the midwife's accomplished self-assessment form and reviewing/discussing it with the midwife.

Monitoring Tool For Practicing Midwives
Supervisor portion: Suggested Steps

There are several advantages to conducting the monitoring this way:

- The supervisor's assessment will not be influenced by the midwife's answers
- Time will be saved
- The midwife's business need not be interrupted; the presence of the midwife will be required only during the exit feedback

Monitoring Tool For Practicing Midwives
Supervisor portion: Suggested Steps

*Using the **Supervisor's Assessment Tool**, the supervisor will rate the clinic or the midwife's performance by doing the following:*

Actual client-service provider interaction

Presence or absence of the item in the clinic

Conduct of regular business in the clinic

Interviewing the midwife, assistants, patients or clients *(least priority)*

Monitoring Tool For Practicing Midwives
Supervisor portion: Suggested Steps

"**SUPERVISOR RATING"** as follows:

- number **"2"** if the assessment of the item is assessed as **Yes/satisfactorily done"**
- number **"0"** in the box if the item is assessed as **"No/not done"**
- **"NA"** if the question is not applicable to the clinic,
- number **"1"**in the box if the assessment is **"Yes, but needs improvement"**

Monitoring Tool For Practicing Midwives
Supervisor portion: Suggested Steps

After answering the questions in each of the six components in the assessment tool, the supervisor will compute for the scores for each component and accomplish the "Supervisor's Scoring Sheet"

PART 2: Supervisor's (Numerical) Scoring Sheet

- Numerical score summary
- Objective measurement of quality of service provision

I. FACILITY

Indicator A. Conditions/ Amenities (12 items)	Indicator B. Facility/ Infrastructure (12 items)	Indicator C. Educational Materials for Clients (3 items)	Indicator D. Professional Appearance of Provider (1 item)	Total Score (28 items)	Comment
1 2 8 2 2 1 9 2 3 2 10 2 4 2 11 1 5 2 12 1 6 0 7 1 Score: 18 / 24	1 2 8 2 2 1 9 2 3 0 1 2 4 1 1 2 5 2 1 2 6 2 7 2 Score: 20 / 24	1 0 2 0 3 0 Score: 0 / 6	1 2 Score: 2 / 2	Score: 40 / 58	

Monitoring Tool For Practicing Midwives
Supervisor portion: Suggested Steps

"Supervisor's Scoring Sheet"

- The very first time these component scores are recorded, it will comprise **the clinic's baseline component scores.**
- Scores recorded from subsequent monitoring visits will objectively document whether the facility is improving or deteriorating in the quality of its provision of FP/MCH services and supplies.

Monitoring Tool For Practicing Midwives
Supervisor portion: Suggested Steps

Once the Scoring Sheet is completed, the supervisor can request the midwife to participate in an exit feedback session.

Monitoring Tool For Practicing Midwives
Supervisor portion: Suggested Steps

The following steps may comprise the exit feedback:

- Request for the accomplished Midwife Profile sheet (keep this as record for the database on midwives or simply as a baseline record for your office);
- Review the self-assessment answers with the midwife by either going through each question one by one, or, by….

SECTION 4

Guide to Organizing and Managing the Conduct of Clinical Case Conference for Midwives

Section 4: Guide to Organizing a Clinical Case Conference

Duration: 20 minutes

Objectives: At the end of the session, the participants will have an overview of what a clinical case conference (CCC) is, how it is organized, how it is conducted, and what the possible roles of midwives are.

Materials Needed: None

Methodology: Lecture

Process: Discuss briefly the following:

1. What is a clinical case conference?
2. How is a CCC organized?
3. How is a CCC conducted?
4. What are the resources needed for a CCC?
5. What are possible roles for midwives?
6. What are their plans in organizing a CCC in their respective areas?

PowerPoint Slides

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Section 2

A Guide to Organizing and Managing the Conduct of Clinical Case Conference for Midwives

Organizing & Managing Clinical Case Conference for Midwives

Objective of the manual:

- Seeks to formalize and sustain CCC for midwives as a guide towards Continuing Quality Improvement (CQI)
- Midwives, physicians and participants should come out of the conferences with improved knowledge and assurance that they have gained as partners, not competitors, improving the lives of mothers and children

This does not replace the Maternal Death Review

Organizing & Managing Clinical Case Conference for Midwives

Five parts:

- Organizing guidelines
- Conference objectives
- Structure of the conference
- Steps in organizing
- Appendices

Organizing & Managing Clinical Case Conference for Midwives

– Organizing guidelines

- General guidelines – positive venues for learning
- Tasks and responsible organizations – Lead agency
  - – Lead Agency to gather prospective cases
  - – Writing the case – need sample case and capacity to write the case
- Participants – include professional practicing midwives
- Timelines
- Preparatory activities

Organizing & Managing Clinical Case Conference for Midwives

Conference objectives

- General Objectives
- Specific Objectives

Organizing & Managing Clinical Case Conference for Midwives

Structure of the Conference

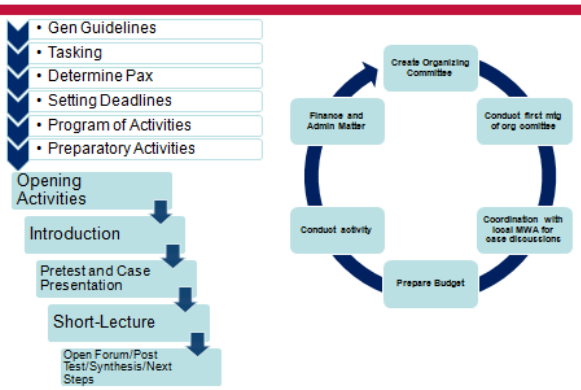
- Opening activities
- Introduction
- Pre-test
- Case Presentation
- Short lecture
- Open forum
- Post-test
- Synthesis
- Next steps

Organizing & Managing Clinical Case Conference for Midwives

Steps in organizing

- Creation of the organizing committee
- Making the organizing committee functional
- Coordination with local Midwives' Associations to gather and select the case for discussion in the conference
- Budgetary preparation
- Conduct of the activity itself
  - – Pre-event in the conduct of meeting with MW group to discuss conference ground rules
  - – Post-event in the conduct of meeting with organizing committee members

Organizing & Managing Clinical Case Conference for Midwives



Organizing & Managing Clinical Case Conference for Midwives

Sustaining the CCC for Midwives

- Financial requirements
- Consolidating CCC documentations
- Utilization of the lessons learned during CCCs
- Main driver for the CCC

Organizing & Managing Clinical Case Conference for Midwives

- Where in your place is the CCC being conducted?
- What are the lessons learned while conducting the CCC?
- Is there a need for CCC?
- Is there a need to train midwives on CCC?
- Where in your area will the CCC be needed?

Midwives Concerns in the Conduct of CCC

Objectivity

- The need to open discussions with the Midwives Association and members
- The need to appreciate the role of Quality Assurance in the provision of continuing quality improvement

Capacity

- Preparation and making case study presentation
- Clinical standards of care – QAP

Midwives concerns in the Conduct of CCC

Social Mobilization

- How to actively be involved in activities of MAs
- How to mobilize and tap resources

Information, Education, Communication

- Correspondence
- Promotions
- Documentation

Possible roles of the MWs/PPMs in the Organizing and Conduct of CCC

Can be a source of the case to be discussed

- Case is presented anonymously: health provider/MW and patient are not identified
- Must be willing to fully disclose all details of the case including, but not limited to, chronology of events, procedures done, etc.
- Usually, not the case presentor

Possible roles of the MWs/PPMs in the Organizing and Conduct of CCC

Can be a participant/attendee in the CCC

- Must be open to gaining knowledge as a result of the discussion
- If originator of the case,
  - May opt to join the discussion without revealing her identity as MW involved in the case
  - Must be "emotionally-detached"
  - Must not be defensive during the case discussion

Annexes

ANNEX A: Pre/Post-Test

PRE- / POST- TEST

Name: _____

Date: _____ Venue: _____

Write the letter of the best answer on the blanks:

_____ 1. When a client comes to the clinic for prenatal consult, which of the following should you do first?
A. Assess for the presence of any danger sign of pregnancy
B. Prepare the Maternal Birth Plan
C. Confirm the pregnancy
D. Do Basic Prenatal Care

_____ 2. The following is a danger sign of pregnancy except:
A. Abdominal pain
B. Nausea
C. Headache
D. Fever

_____ 3. When should you start giving Tetanus Toxoid in a pregnant woman?
A. 1st trimester
B. 2nd Trimester
C. 3rd Trimester
D. TT should not be given during pregnancy

_____ 4. When the cervix is 5cms dilated, the woman is in which stage and phase of labor?
A. 1st Stage of Labor, Latent Phase
B. 1st Stage of Labor, Active Phase
C. 2nd Stage of Labor, Early Phase
D. 2nd Stage of Labor, Late Phase

_____ 5. Oxytocin, 10iu, is given intramuscularly, after cord clamping.
A. True
B. False

_____ 6. Vitamin K injections should be given:
A. Within 10 minutes after delivery
B. 10-30 minutes after delivery
C. Within 90 minutes after delivery
D. 90 minutes-6 hours after delivery

_____ 7. All Midwives are expected to do which of the following:
A. Newborn Screening
B. Repair of 1st degree lacerations
C. Leopold's Maneuver
D. Bimanual Compression of the uterus

_____ 8. In the GATHER Approach, A means:
A. Assist the patient
B. Answer the patient's questions
C. Ask what you can do for the patient
D. AOG of the patient

_____ 9. What is the proper way of cleaning instruments?
A. Soak in 0.5% chlorine solution, Clean with soap & water; Sterilize
B. Clean with soap & water, Soak in 0.5% chlorine solution; Sterilize
C. Clean with soap & water; Sterilize by boiling; Autoclave
D. None of the above

_____ 10. A client who just delivered 3 months ago came to your clinic because she does not want to get pregnant again for the next 4 years. What form will you use?
A. Maternal Birth plan
B. Maternal Service Record
C. Family Planning Form
D. Outpatient Service Record

ANNEX B: Answer Key to Pre/Post-Test

ANSWER KEY TO PRE- / POST-TEST

Name: _____

Date: _____ Venue: _____

Write the letter of the best answer on the blanks:

__C__ 1. When a client comes to the clinic for prenatal consult, which of the following should you do first?
- A. Assess for the presence of any danger sign of pregnancy
- B. Prepare the Maternal Birth Plan
- C. Confirm the pregnancy
- D. Do Basic Prenatal Care

__B__ 2. The following is a danger sign of pregnancy except:
- A. Abdominal pain
- B. Nausea
- C. Headache
- D. Fever

__A__ 3. When should you start giving Tetanus Toxoid in a pregnant woman?
- A. 1st trimester
- B. 2nd Trimester
- C. 3rd Trimester
- D. TT should not be given during pregnancy

__B__ 4. When the cervix is 5cms dilated, the woman is in which stage and phase of labor?
- A. 1st Stage of Labor, Latent Phase
- B. 1st Stage of Labor, Active Phase
- C. 2nd Stage of Labor, Early Phase
- D. 2nd Stage of Labor, Late Phase

__B__ 5. Oxytocin, 10iu, is given intramuscularly, after cord clamping.
- A. True
- B. False

__D__ 6. Vitamin K injections should be given:
- A. Within 10 minutes after delivery
- B. 10-30 minutes after delivery
- C. Within 90 minutes after delivery
- D. 90 minutes-6 hours after delivery

__C__ 7. All Midwives are expected to do which of the following:
- A. Newborn Screening
- B. Repair of 1st degree lacerations
- C. Leopold's Maneuver
- D. Bimanual Compression of the uterus

__C__ 8. In the GATHER Approach, A means:
- A. Assist the patient
- B. Answer the patient's questions
- C. Ask what you can do for the patient
- D. AOG of the patient

__A__ 9. What is the proper way of cleaning instruments?
- A. Soak in 0.5% chlorine solution, Clean with soap & water; Sterilize
- B. Clean with soap & water, Soak in 0.5% chlorine solution; Sterilize
- C. Clean with soap & water; Sterilize by boiling; Autoclave
- D. None of the above

__C__ 10. A client who just delivered 3 months ago came to your clinic because she does not want to get pregnant again for the next 4 years. What form will you use?
- A. Maternal Birth plan
- B. Maternal Service Record
- C. Family Planning Form
- D. Outpatient Service Record

ANNEX C: Levelling of Expectations (Pre-printed Tarpaulins)

RATE THE FOLLOWING ITEMS BY PLACING A **BLUE METACARD** ON YOU **STRONGEST POINT** AND A **PINK METACARD** ON THE **AREA THAT NEEDS IMPROVEMENT** AS A MIDWIFE.

❑ **Planning**	
❑ **Clinical Skills**	
❑ **Filling out Forms**	
❑ **Data Analysis and Assessment**	
❑ **Referrals**	
❑ **Problem Solving**	
❑ **Decision Making**	
❑ **Others (specify)**	

WHAT PROCESSES/ PROCEDURES/ METHODS DO YOU EXPECT FROM THIS QAP TRAINING THAT MAY BOOST YOUR ROLE(s) AND FUNCTION(s) AS A MIDWIFE? PUT A **GREEN METACARD** ON ALL THAT APPLIES TO YOU.

❑ **Self-Assessment Checklist/Tool**	
❑ **Planning Sessions**	
❑ **Capacity Building/ Retooling**	
❑ **Clinical Case Conference**	
❑ **Fund Sourcing**	
❑ **Service Provision Profiling/ Baselining**	
❑ **Records Keeping and Feedbacking**	
❑ **Others (specify)**	

ANNEX D: Quality Assurance Package for Midwives Orientation Workshop (Programme)

Day 1	
8:00 AM	Participant Registration
9:00 AM	Invocation
	National Anthem
9:10 AM	Welcome Remarks
9:20 AM	Pre-test
9:30 AM	Levelling of Expectations
9:45 AM	Overview of the Program / Objectives
	Rationale for the QAP
10:00 AM	Workshop - *Clinical Care for Midwives*
12:30 NN	LUNCH
1:30 PM	Workshop - *Clinic Operation Standards*
	What forms to use / how to accomplish each form
	Case Study - How to use the Partograph
4:30 PM	Synthesis of Day 1
Day 2	
8:30 AM	Registration of Participants
9:00 AM	Lecture – Midwife's self-assessment tool
9:30 AM	Workshop – Midwife's self-assessment exercise
11:30 AM	Processing the self-assessment
12:00 NN	LUNCH
1:00 PM	Continuation – Processing the self-assessment
2:00 PM	Action Plans / Next Steps
3:00 PM	Guide to Organizing and Managing Conduct of Clinical Case Conference for Midwives: Didactics & Practical Application
3:30 PM	Post-test
3:45 PM	Synthesis of Day 2
4:00 PM	Closing

ANNEX E: Quality Assurance Package for Midwives Orientation Workshop (Checklist)

ITEM	MATERIALS	DONE
1. Attendees	List of Participants	
2. Invites	Invitations/Programme emailed / sent	
	Attendance confirmed	
3. Venue	Venue for the activity confirmed	
4. Accommodations	Place & No. of rooms confirmed (if necessary)	
5. Training : Materials to be distributed (per participant) ; put in 1 expandable plastic envelope	Quality Assurance Package Manuals (QAP)	
	CD containing the following: QAP Manual 2013, Midwife's self-assessment tool, Powerpoint presentations, Workshop sheets, Forms, Partograph	
	Actual Hard Copy of all the forms : (put in L-type folder)	
	QAP programme	
	Self-Assessment tool for Midwives - hard copy	
	Forms - 1, 2A, 2B, 2C, 2E, 3, 4, 5 (1 copy each) - hard copy	
	Form 2D Partograph (2 copies each)	
	1 pencil	
	extra bond papers/notebook	
6. To be printed but not included in the Kit (to be distributed / used during the workshop)	Workshop sheets	
	Evaluation Form (Annex G)	
	Pre-test	
	Post-test	
	Tarpaulins of Forms : size 35"x54" for Forms 1, 2A and 2B and size 35"x48" for Forms 2C, 2D, 2E, 3, 4, 5	
	Tarpaulin for Levelling of Expectations - 20"x30" each	
9. Office Supplies	Washable Pentel pens	
	Meta Cards (3 colors - pink, blue, green)	
	Extra bond papers	
10. Equipment	LCD projector	
	Projector Screen	
11. Other materials	Attendance sheet	
	Name Tags	
	Certificates of Completion	
	Certificate of Appearance	

ANNEX F: Action Planning Form for Midwives

Issues/ Areas for Improvement	Root Causes (WHY)	Solutions/Interventions	Action Plans/Next Steps	By Whom	By When

ANNEX G: Evaluation Form

ACTIVITY: QAP for Midwives

DATE: _____ **VENUE:** _____

EVALUATION FORM

YOUR EVALUATION WILL BE APPRECIATED AND IT WILL HELP US IMPROVE OUR NEXT ACTIVITY.

Please rate lecture/activity by checking the box corresponding to the numerical score on the appropriate column.
Please submit this evaluation form as you leave the room on the last day.

ACTIVITY / LECTURE	Pace of lecture / session					Content					Quality of visual aids / materials					Overall Impression				
	POOR ⇨ GOOD					POOR ⇨ GOOD					POOR ⇨ GOOD					POOR ⇨ GOOD				
	1	2	3	4	5	1	2	3	4	5	1	2	3	4	5	1	2	3	4	5
DAY 1																				
Workshop on the Clinical Care for Midwives																				
Workshop on Clinic Operations Standards																				

ACTIVITY / LECTURE	Time Alloted for Activity/ Pace of lecture					Content					Applicability of Practicum Site / Quality of visual aids					Overall Impression				
	POOR ⇨ GOOD					POOR ⇨ GOOD					POOR ⇨ GOOD					POOR ⇨ GOOD				
	1	2	3	4	5	1	2	3	4	5	1	2	3	4	5	1	2	3	4	5
DAY 2																				
Workshop on MW Self-Assessment																				
Lecture on Clinical Case Conference																				

LOGISTICS :	Overall Impression				
	POOR ⇨ GOOD				
	1	2	3	4	5
LECTURE ROOM					
FOOD					
SOUND SYSTEM					
PERSONNEL STAFF					

OTHER COMMENTS / SUGGESTIONS:

SUGGESTIONS FOR TOPICS IN NEXT ACTIVITY: